"Understanding health policy change in post-dictatorship Chile (2000-2006) an Advocacy Coalition Framework analysis".

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UNDERSTANDING HEALTH POLICY CHANGE IN POST DICTATORSHIP CHILE (2000-2006): AN ADVOCACY COALITION FRAMEWORK ANALYSIS

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ABSTRACT

This thesis examines the political process of the health reforms enacted in Chile during the Presidency of Ricardo Lagos (2000-2006). The Advocacy Coalition Framework (ACF) is used to answer the question: **How were the health reforms during the Lagos administration of 2000-6 achieved within the existing institutional arrangements that were put in place during the authoritarian period?** As emphasised by the historical institutionalist literature, Chilean politics, since the return to democracy, has been characterised by inertia and limited transformation. My research seeks to understand how it was possible to bring about policy change in a context in which everything seemed fixed. The contribution of this thesis is twofold: first, examining the health policy reform through the lens of the ACF, this study contributes to expand the theoretical development of this framework. Second, this study contributes to enrich the existent literature about the Chilean case, analysing original data to identify the factors that enable policy change.

Focusing on explanations for policy change suggested by the ACF, the findings suggest that health reform was achieved through a path of negotiated agreement. This agreement was facilitated by three main factors: an evolution of coalitions, the strategic mobilisation of resources, and the institutional arrangements inherited from the authoritarian regime.

Using a qualitative case study, informed by the international health policy literature, and using the ACF as a theoretical framework, the Chilean case is scrutinised. Evidence was gathered through an appraisal of data collected from a variety of documentary sources, as well as the thematic analysis of transcriptions of congressional hearings and 26 semi-structured elite interviews. Applying ACF allowed me to identify and understand the dynamics of the Chilean health reforms, by examining how actors grouped into coalitions, shared belief systems, and acted strategically to determine the outcome of the reforms.

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ABBREVIATIONS

Abbreviation	English	Spanish
ACF	Advocacy Coalition Framework	Enfoque De Coaliciones Defensoras
AFP	Administrator Of Pension Funds	Administradora De Fondos De Pensión
AUGE PLAN	Plan Of Explicit Guarantees Of Access	Plan AUGE
CIEPLAN	Centre for Economic Research on Latin America	Corporación de Estudios de Economía para Latinoamérica
CM	Medical Association	Colegio Medico
CONFENATS	National Federation Of Health Workers	Federación Nacional De Trabajadores De La Salud
CONFUSAM	National Confederation of Municipal Health Civil Servants	Confederación De Trabajadores De La Salud Municipal
CONGRES	National Council Of Healthcare Unions	Consejo de Gremios de la Salud
CPC	Confederation For Production And Commerce	Confederación De Producción Y Comercio
ECLAC	Economic Commission for Latin America and the Caribbean	Comisión Económica para América Latina y el Caribe
EU	European Union	Unión Europea
FCS	Solidarity Compensation Fund	Fondo De Compensación Solidario
FMS	Maternity Solidarity Fund	Fondo Maternal Solidario
FONASA	National Health Fund	Fondo Nacional De Salud
(IDB)	Inter-American Development Bank	Banco Interamericano de Desarrollo
IMF	International Monetary Fund	Fondo Monetario Internacional
INP	Institute Of Pension Fund Normalization	Instituto De Normalización Previsional
ISAPRES	Private Health Insurance Funds	Instituciones De Salud Previsional
MINSAL	National Health Minister	Ministerio De Salud
ODEPLAN	National Planning Bureau	Oficina De Planificación Nacional
OECD	Organisation for Economic Co-operation and Development	Organización Económica para la Cooperación y el Desarrollo
PC	Communist Party	Partido Comunista
DC	Christian Democrat Party	Partido Demócrata Cristiano
UNDP	United Nations Programme for Development	Programa de Naciones Unidas para el Desarrollo
PPD	Party For Democracy	Partido Por La Democracia
PS	Socialist Party	Partido Socialista
PRSD	Radical Social Democratic Party	Partido Radical Social Demócrata
RN	National Renewal	Renovación Nacional
SERMENA	National Medical Service For Employees	Servicio Médico Nacional De Empleados
SOFOFA	Federation Of Chilean Industry	Sociedad Of Fomento Fabril
SNS	National Health System	Sistema Nacional De Salud
SNSS	National Health Services System	Servicios Del Sistema Nacional De Salud
UDI	Democratic Independent Union (Right Wing Political Party)	Unión Demócrata Independiente
UNDP	United Nation Development Programme	Programa para el Desarrollo Naciones Unidas
VAT	Value Added Tax	Impuesto Al Valor Agregado (IVA)
WB	World Bank	Banco Mundial
WHO	World Health Organisation	Organización Mundial de la Salud

CHAPTER 1 INTRODUCTION

The study of political transitions during the eighties and nineties became an important issue in the analysis of health policy, as democratisation processes were seen as an opportunity to introduce policy changes. Indeed, the combination of demographic and epidemiological evolutions, technological advances in medical areas, economic crises, and the transitions from authoritarian to democratic regime changes, led to a wave of health policy reforms globally (Kuhlmann, Blank, Bourgeault, and Wendt 2015). Following the market-oriented recommendations of international financial institutions such as The World Bank (WB) and The International Monetary Fund (IMF), a number of countries took steps to implement health policy reforms to improve efficiency and productivity (World Bank 1993; Kaufman and Nelson 2004; Haggard and Kaufman 2008). In this sector, the main policies adopted in a democratisation context involved fiscal constraints and cuts to the public sector, the inclusion of private sector institutions as providers and insurers, and a decentralisation of financing and managerial responsibilities from central to regional and municipal authorities (Gonzalez and Bossert 1999; Mesa Lago 2005; Kuhlmann et al. 2015).

The structural reforms carried out during the authoritarian regime of Augusto Pinochet (1973-1990) in the health sector are good examples of this phenomenon. Furthermore, the Chilean example provides a useful case to explore how new policies was introduced by post-authoritarian governments. To locate this topic, it must be highlighted that Chile started introducing the market-oriented radical reforms earlier than the rest of Latin America, and before the political transitions that took place elsewhere. The public health system, which emerged in Chile in 1952 following the British NHS model, was transformed by the Pinochet regime in 1981 into a segmented system that positioned healthcare as a commodity rather than an entitlement. This system was comprised of both a National Health Fund (FONASA) and Private Health Insurance Funds (ISAPRES), who acted as both insurers and providers (Jimenez and Bossert 1995; Castiglioni 2005). By the end of the authoritarian period, the sector accumulated a number of shortages due to cutbacks in public expenditure, low investment in infrastructure, and a lack of regulation for the private market around the ISAPRES (Barrientos 2002; Taylor 2003). The return to democracy in 1990 marked a turning point to introduce major changes to correct the deficiencies created by the dual system.

However, despite the expectations created by the political transition to liberal democracy, the first two democratic governments, led by the Christian Democratic Presidents Patricio Aylwin

(1990-1994) and Eduardo Frei (1994-2000) of the *Concertacion*[1], postponed the implementation of radical reforms to prevent any potential destabilisation from the military. The political stability of the transitional period was accompanied by a booming economy, known as the "Chilean miracle"[2] (Landerretche 2014), but no significant reforms were made in the social policy sectors (Pushkar 2006; Gideon 2007).

The scholarly literature has suggested that, in this post-authoritarian period, the Chilean political system has been characterised by structural inertia and the inability for political elites to bring about substantial transformations. Some authors relate this immobility to the consensus-driven policy style adopted by the new democratic governments, which, despite the participatory environment of democracy, aims to restrict substantial transformations through informal and 'behind the doors' practices (Richardson 1981; Pribble 2013; Gideon 2014). In the same vein, many argue that this lethargy has been the result of the institutional arrangements inherited from the dictatorship). They argue that these arrangements have constrained both the formal decision-making processes and the political will of the democratic authorities (Gonzalez-Rossetti, Chuaqui, and Espinosa 2000; Castiglioni 2005; Pushkar 2006; Ewig and Kay 2011; Siavelis 2016).

Therefore, the question is, how in such a constrained context do reformers achieve shifts in public policy direction? Indeed, the major health reform announced by the new socialist Chilean President Ricardo Lagos in May 2000 was the first attempt at changing social policies since the return of democracy. He declared that the central objective of the bill was to expand citizens' rights, provide guarantees for access and financial protection for the health service, and to correct the deficiencies of the neoliberal reform of 1981[3]. Congress approved the last bill of this reform in May 2005, after a long process of discussion and negotiation.

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[1] The *Concertación* was a centre-left electoral pact composed of the Christian Democratic Party (PDC), Socialist Party (PS), Social Democratic Radical Party (PRSD) and The Party for Democracy (PPD) that ruled Chile from 1990 to 2010. The opposition formed the *Alianza* bloc, comprised of two right-wing parties: Independent Democratic Union (UDI) and National Renovation (RN).

[2] This growth was especially notable when compared to other Latin American countries, with a GDP growing at around 7% from 1990 until 1996. However, in the second half of 1998, due to the Asian financial crisis, Chile experienced a major slowdown and GDP per capita fell of -0.8% in 1999 (Oppenheim 2006).

[3] The content of President Lagos' reform is explained in Chapter 4.

Lagos's health reform can therefore be seen as a landmark development in the post-authoritarian landscape of Chile, as it would bring about improvements in the health sector and break from the prevailing policy inertia of the period. This thesis seeks to explore this issue using the case of the health system reform during the Lagos administration of 2000-2006. Using a fine-grained analysis informed by the Advocacy Coalitions Framework (ACF) it examines how, in a context in which everything seemed fixed, it was possible to break the inertia and bring about policy change. Consequently, the contribution of this thesis is twofold: first, to examine this reform through the lens of the ACF, contributing to expand the theoretical development of this framework; and second, to enrich the existent literature about the Chilean case with original data to analyse the factors that enabled policy change in the health sector

1.1 RESEARCH QUESTION AND SIGNIFICANCE

In the light of the difficulties of changing the direction of public policy in post-authoritarian regimes, and the lack of research examining that enabled policy change in such contexts, the research question that guides this study is as follows:

> ***How was the health reform during the Lagos administration of 2000-2006 achieved within the institutional arrangements that had been put in place during the authoritarian period?***

In answering this question, this thesis draws on the work of Sabatier and Jenkins-Smith (1993), Sabatier and Weible (2007) and Jenkins-Smith, Nohrstedt, Weible and Sabatier (2014) to argue that policy change effectively occurred despite the institutional constraints. The Advocacy Coalition Framework (ACF), developed by these authors, offers a framework for moving beyond the focus on stability of previous studies. According to this approach, major or minor policy changes do occur, and to understand the how's and why's of the process, one should look at the beliefs, strategies and interactions of advocacy coalitions within a specific policy subsystem (Sabatier and Jenkins-Smith 1993; Weible, Sabatier, and Flowers 2008). Unlike other theories in the same field, the ACF postulates that policy change, rather than being caused by a specific moment, could be the result of a continuous process affected by a number of variables (Ganon et al. 2007; Sabatier and Jenkins-Smith 2007; Jenkins-Smith et al. 2014). Looking at the coalitions involved in the

health reform process in Chile, a further sub-set of enquiries arises from the theoretical framework: What was the role of coalition structure in explaining the policy change? How did the distribution of resources and the use of various strategies influence policymaking in this case? How did institutional arrangements and policy legacies affect coalition interactions? The answers to these queries will be explored further in the discussion of the thesis, to explain how this reform was approved. As such, the focus of Sabatier and colleagues is especially useful to this analysis, as it allows for an examination of how actors overcame the obstacles posed by the legacies of the non-democratic period.

There are some limitations in applying the ACF to post-authoritarian cases that this thesis seeks to address. Early studies using this framework tended to overlook two main elements for explaining policy change. First, the initial work on ACF was largely developed in the pluralist American context and has only recently been used in studies beyond the US. Thus, few studies have explored the effects of variations in institutional arrangements, or as they are called in the ACF, opportunity structures, in coalition interactions. Recent work has enriched this strand of the framework by examining cases in non-democratic regimes (Han et al. 2014 in China), and the role of democratisation in explaining policy change (Carvalho 2001 in Brazil; Arnold 2003 in Chile; Freigedo, Fuentes, and Rodríguez Araújo 2015 in Uruguay). However, more research is still needed to understand how coalitions are shaped by different contexts.

Second, much of the literature that has applied the ACF framework so far, whether in democratic, transitional, or authoritarian regimes, has stressed that policy change is explained by events occurring outside the policy subsystem. These exogenous events include the democratisation process, the enactment of a new constitutions, and more recently, the accession to the European Union (Bukowski 2007; Albright 2011), but considerably less attention to alternate drivers for policy change (Weible et al. 2011). Consequently, this thesis aims not only to understand how a policy shift occurred in the Chilean health sector, but it also seeks to contribute towards a theoretical improvement examining different paths and mechanisms for policy change proposed by the ACF.

Regarding the study design and methods, my thesis follows the qualitative strand of previous studies on the ACF, using a qualitative case study, an approach that allows an in-depth investigation of the policy process, seeking to explore the responses to questions about how decisions were made and why some policies were more feasible than others. The time-period

examined by my research spans from the announcement of the reform by President Lagos in May of 2000, including the processes of design and negotiation, until the last bill was approved at the Congress in May of 2005.

1.2 RELATED WORK

Taking the contribution of previous pieces of research as a background for this study into account, the effects of the Chilean process of democratisation into the analysis of the health sector has attracted the attention of several scholars[4]. Specifically, the starting point of this research is motivated by those studies that have previously examined the features of the political process of the health reforms in Chile, (see e.g. Castiglioni 2005, 2006; Davila 2005; Ewig and Kay 2011; Pribble 2013). These studies have adopted a historical institutionalist approach, looking at institutions as a result of historical processes and explanatory variables for health policy change. According to this perspective, the trajectory and outcomes of the political process are determined through the rules and norms of the political system. As it will be explained further in Chapter 2, the concepts of path dependency and policy feedback are used in this body of knowledge, to assess the repercussions of institutions created in the past on future decisions (Hall and Taylor 1996; Pierson 1996; Thelen 1999).

Much of the literature about the Chilean case points out that the lack of change introduced by The *Concertación* to Pinochet's health system was a consequence of the institutional arrangements set up during his dictatorship. Some of the authors emphasise institutions such as, those created by the 1980 Constitution, or the checks and balances between the executive and legislative branches, and the prerogatives of each to push policy change forward (Castiglioni 2005; Pushkar 2006). Others focus on the character of political parties (Pribble 2013) or the actors that emerged from the partial privatisation of the health system, which opposed any change to the status quo (Ewig and Kay 2011). All these authors agree that Chilean politics seemed mired in

[4] Health related literature that has explored the effects of democratization in other areas includes: inequality (Barrientos 2002; Ewig and Palmucci 2012), poverty (Lloyd Sherlock 2013, Pribble 2008), health indicators (maternity care in Murray and Elston 2005; infant mortality in McGuires 2010), gender policies (Gideon 2014; Waylen 2014), and policy diffusion of social policies (Weyland 2005, 2006).

what Pushkar (2006) called “a paralysis in [the] health sector” due to deeply rooted obstacles in the political system created by the institutional arrangements of the authoritarian period (Jimenez and Bossert 1995; Gonzalez-Rossetti, Chuaqui, and Espinosa 2000; Castiglioni 2005). In spite of these interpretations, the examination of the factors that facilitated policy change in this context has remained unclear. Thus, examining the shift in the health sector during President Lagos’ period is a good case as it shows policy change against the odds. To do so, this thesis explores an alternate theory to policy change, the Advocacy Coalition Framework, to unpack the particularities of the political process that prompted a significant change in the health sector.

1.3 THESIS OUTLINE

Following this introduction, **Chapter 2** presents a synthesis of the existing research on health policy reforms. It begins with an overview of the main theories and concepts used in the analysis of health policy reforms. In the second section, it moves on to existing research on health policy reforms in countries that experienced transitions to democracy. The last section is devoted to reviewing the latest literature on Chilean health reform. It explains the institutional arrangements set up during the authoritarian period, which is featured in this literature as the main obstacle for policy change in Chile after the regime transition. It concludes that, despite these policy legacies, policy change did occur, thus breaking the stability often observed in the literature. Finally, it demonstrates how this thesis seeks to fill this gap.

Chapter 3 considers in detail the theoretical framework of this thesis, which draws out the particular value of the Advocacy Coalition Framework (ACF) for this type of inquiry. Its focus on analysing how actors grouped into coalitions are able to push policy change forward in a context of continuity makes it the most suitable approach for elucidating how policy change occurred in the Chilean health sector. The last section of the chapter deals with the application of this approach in post authoritarian countries. This section unveils the paths of policy change and the implications of institutional arrangements in this process. It concludes by highlighting the potential contributions of this study in expanding the knowledge of the ACF in these two aspects.

Chapter 4 provides an overview of the Chilean health system and the developments in this sector during and after the authoritarian regime, to put the results of this research into context. The milestones of both the authoritarian and democratic periods are presented, in addition to the

characteristic of the private and public sectors. It also explains the content of the health policy reform proposed in 2000 in more detail. This chapter sheds light on the issues discussed during the political process, as well as the actors and organisations involved in the sector.

Chapter 5 explains the research design and methodology adopted in this study, providing a detailed account of the data collection and analysis. In the first part, it argues for the appropriateness of the qualitative case study method for answering the research questions, based on previous ACF studies. Empirical data, mainly gathered in two fieldwork stages in Chile, comes from semi-structured elite interviews, transcripts of congressional hearings, and other documentary sources. The data was examined following a deductive approach, and then progressed to a further thematic analysis for the theoretical framework of this study. The last section gives a reflexive evaluation of the fieldwork process.

Chapters 6, 7, and 8 report the empirical findings from the analysis of the data collected. Each chapter is organised into three sections corresponding to the main themes of the ACF analysed. **Chapter 6** identifies the coalitions within the health policy subsystem in two different phases of the process, categorises them according to their viewpoints of the proposed government reform, and explores the interactions between them. The evolution from four initial competitive coalitions to one collaborative coalition is a key factor in explaining the approval of the bill. **Chapter 7** looks at how coalitions use resources and strategies to modify the policy process according to their objectives. It focuses on the mobilisation of public opinion, the function of expert knowledge and technical information developed within opponent groups, and the role of policy brokers as facilitators for policy change. **Chapter 8** considers the effects of broader institutional arrangements and policy legacies from the authoritarian period and their implications on the health sector reforms. The effects of political participation, the electoral system, and the presidential powers are factors that emerged from the data as important in this context.

Chapter 9 takes the analysis of the findings forward into a detailed discussion about the empirical and theoretical implications of this investigation. It assesses the extent as to which we can gain a better understanding of changes in policy-making in post-authoritarian Chile by contextualising the health policy reform within the ACF and health policy literature. Conversely, it gauges the contribution of the Chilean case analysis to a nuanced development of the ACF. The chapter ends with a summary of key conclusions of the thesis, discusses the limitations of this research, and identifies relevant topics for future studies.

CHAPTER 2 UNDERSTANDING HEALTH REFORMS IN A CONTEXT OF DEMOCRATISATION

2.1 INTRODUCTION

Having presented in the previous introduction the research problem, background, and theoretical framework of this thesis, this chapter considers the state of knowledge on health reform processes in contexts of post-authoritarian democratisation. This chapter begins reviewing the main theories and concepts used in the welfare states literature on advance industrialised countries, focusing on the historical institutionalist approach and the concepts of policy legacies and veto points in the analysis of health policy reforms. These concepts have also been applied to understand the feasibility of the implementation of policy reforms in post authoritarian countries, taking into account the institutional arrangements established in a non-democratic context as factors that may facilitate or constraint policy change in this sector.

In the first part of the chapter, I introduced the contributions from welfare states and historical institutionalist literature for the understanding of health policy change. The second section presents the implications of this approach for the analysis of countries that have experienced transitions from authoritarian regimes to democracy. In particular, it emphasises the effects of political participation and institutional arrangements from former regimes in health sector reforms. The remainder of this section presents existing literature on Chile's health reforms, explaining the institutional veto points and policy legacies from the Pinochet regime, and the implications of these institutional arrangements on policy change. This section concludes indicating the gaps of previous studies and how this thesis will address these limitations.

2.2 BACKGROUND OF HEALTH POLICY REFORM STUDIES

The existing literature on health policy reforms generally draws upon theories regarding the development of social protection systems in welfare states in advanced industrial democracies (Esping-Andersen 1990; Castiglioni 2005; Hassenteufel and Palier 2008; Beland 2010; Contreras and Sehnbruh 2014). While early works sought to explain developments during "the golden age" of welfare states, based on economic growth and industrialisation, later studies focused on the retrenchment of social programmes during the eighties. The cutbacks of this period were a consequence of several processes: economic constraints, political struggles and ideological drivers, demographic transition, as well as technological advances that increased the complexity of the health sector, stressing the necessity for substantial transformations within the area (Pierson 1994, 2000; Collins et al. 1999; Korpi 2001; Huber and Stephens 2001; Barrientos 2002). Further studies have considered elements such as globalisation, economic integration (Tanzi 2002; Navarro et al. 2004; Starke 2006), ideas (Beland 2010), and policy diffusion (Weyland 2005). Individually or together, these approaches have been employed in the analysis of other policy domains, such as pensions, unemployment, and education, to understand drivers and results of social policy reforms.

This chapter focuses on health sector reforms. Through case studies and comparative analysis, scholars have explored two main explanations regarding the evolution of health policies in Western countries that are related to the focus of this thesis. First, there is research associated with the power resources or class coalitions approach. This strand explains variations in welfare state regimes and health sector outcomes as the results of working-class and political party mobilisation (Esping-Andersen 1990; Huber and Stephens 2001; Korpi 2001). Findings from the first vein of research suggest that social democratic countries led by leftist governments are most likely to promote broader social benefits programmes in coordination with workers' unions, assuming that both entities share social rights values and egalitarian aims. By contrast, conservative and liberal governments, as they seek to reinforce individual capacities over social benefits, are less prone to cooperating with workers in providing social services (Esping-Andersen 1990; Hicks and Swank 1992; Korpi 2001; Huber and Stephens 2001, 2012; Navarro et al. 2004). Adopting a political economic perspective, these studies focus on the impact of class mobilisations in social expenditures and indicators of protection systems such as poverty, inequality, and access (Navarro et al. 2004).

The limitation of these previous pieces of work have to do with their application to other contexts. For example, these studies are not applicable where class coalitions are not at the centre of negotiations, in cases where there isn't a strong leftist party demanding more progressive social policies; or in countries where workers and unions are not active players in the formulation of public policies. For instance, the type of corporatist system existence in some European countries has not been replicated in Latin America (Mares and Carnes 2009). Also, the focus of this literature is the political bargain actors made as proxies of social policy outcomes, but little attention is paid to the contextual factors around policy-making struggles neither to a further elaboration of a qualitative meaning of policy change.

For the purposes of this thesis, I am more interested in understanding the intervening factors in the policy process rather than the quantitative outcomes examined by power resource scholars. In this way, the policy-centred (also known as state-centred) approach is more closely linked to my study. This perspective is focused "on the role of the formal and informal procedures, routines, norms and conventions embedded in the organisational structure of the polity that frames the policy-making process" (Hall and Taylor 1996). Following this perspective, scholars assess the weight of formal and informal institutional settings, which define the "rules of the game" for influencing the policy-making process, on the success or failure of health policy reforms (Immergut 1990; Walt 1994; Steinmo and Watts 1995; Hacker 2004; Marmor and Wendt 2012). These studies are based on historical institutionalism, one of the viewpoints within the institutionalist perspective, which understands institutions as outcomes of concrete historical processes (Hall 1996; Thelen 1999; Beland 2010).

The political dimension of health reform is about the distribution of power (Moran 1995; Bernier and Clavier 2011). At the foci of the institutionalist approach is the understanding of formal institutions based around the typology for majoritarian and consensual democracies elaborated by Lijphart (1999), which defines the environment and mechanisms by which actors can get access to the policy process. Majoritarian democracies (mostly parliamentarian regimes) have a dominant executive branch with a unicameral legislative body and unitary, centralised governments. Institutionally, this type of regime has a single party majority in the executive, a two party system, and majoritarian electoral mechanism. By contrast, in consensual regimes (mainly presidential regimes) power is shared between the executive and the bicameral legislative branches, with federal administrative organisations. According to Lijphart, a consensual democracy is generally comprised of multiparty systems, where various political parties form electoral coalitions to provide

a base of legislative support to the executive branch, which often utilises a proportional representation electoral system for candidates' selection. Lijphart's classification has implications for the study of policy-making, as it offers guidance in looking at the checks and balances of power between the presidency and the congress; the flexibility of constitutions and specific prerogatives of each branch, and the independence of central institutions such as the Central banks, for example.

Following this typology, Immergut (1992) suggests that, in countries where power is dispersed, the feasibility of change decreases as the number of steps involved in policy-making increases. The institutions involved are veto points that delimit the scenarios in which health reforms might be obstructed, creating incentives and constraints for actors engaged in this sector (Immergut 1992; Bonoli 2001; Swank 2001; Immergut and Abou-Chadi 2010). By the same token, the identification of potential obstacles brings about the concept of veto players, which, as defined by Tsebelis (1995, 289) are "individual or collective actors whose agreement is required for a change of the status quo" and might be interest groups, institutional actors, or specific individuals. Altogether, the institutional approach emphasises the examination of veto points and veto players in analysing the feasibility of health reforms (Castiglioni 2005; Beland 2010; Dargent 2012).

The works of Immergut (1990, 1992) in Europe and Steinmo and Watts (1995) in the US, which shed light on institutions as veto points, are regarded as seminal contributions to health sector studies. For instance, Immergut (1990, 1992) explains how veto points work in France, Sweden, and Switzerland. The work investigates the power of medical associations' and how their influence differs according to the features of each country. In those countries with a bicameral Congress, Switzerland and France, there are more barriers to introduce health reforms than in Sweden with its unicameral legislative body. In other words, the organisation and resources of powerful interest groups pressuring against or in favour of the bill are limited by the institutional structures in which they are embedded.

In the same vein, Steinmo and Watts (1995), after the failure of President Clinton's 1993 reform attempt, examined the relationship between veto points and policy legacies in the US. The authors suggest that the combination of a presidentialist, federal, and bicameral government, as veto points, has historically obstructed various attempts to reform the very liberal health system. In addition to this, in the case of Clinton's proposal, through lobbying and campaigning finance activities with Congress representatives, private providers and insurers were crucial veto players in

blocking the bill while it was discussed in the Congress (Steinmo and Watts 1995; Hacker 1998, Tuhoy 1999; Carpenter 2012; Skocpol and Jacobs 2012). Following the concept of 'stickiness' of institutions elaborated by Pierson (1996, 2001), the combination of institutional arrangements and powerful actors involved in the health sector reinforce stability rather than modify it.

From this perspective, two concepts are key to understanding the influence of historical processes in the health sector: policy legacies and path dependency (Pierson 1994; Mahoney 2000; Pierson 2002; Pierson and Skocpol 2002, Haeder 2012). These emphasise the gradualist, rather than radical, pattern of health reforms and stress the idea that past decisions may narrow down the choice set of future political actors (Pierson 1994; Peters et al. 2005). Put simply, once political decisions are made, they become strong barriers to reverse the results of those decisions. Indeed, studies in advanced industrialised countries argue that, in a broader picture, social protection systems have become "frozen landscapes" where the pattern is resistant to radical changes from organised groups defending the status quo (Esping Andersen 1996; Martin and Palier 2008). It would then be fair to say that historical institutionalism strongly emphasises a pathway of stability, where policy legacies and path dependent processes create lock-in effects that obstruct the achievement of changes in health policy. However, this argument about immobility becomes the main weakness of the approach. The institutionalist accounts fail to explain episodes where the status quo is replaced by new policies or a conversion of old configurations into new structures. How can public policy change occur then?

Scholars have acknowledged that notwithstanding the inertia from the institutional arrangements, or 'stickiness', there are specific breakpoints or critical junctures where a historical pathway that may lead to a departure from the past policies gets unlocked (Pierson 2001; Hacker 2002, 2004; Peters et al. 2005; Beland 2010). For instance, the approval of Obama's health sector reform in 2009 contradicts the findings of Steinmo and Watts (1995) who emphasise the unconducive institutional environment in the US. Scholars agree that, under the same institutional framework as previous reform bills, a combination of a Democrat majority in Congress and a less ambiguous proposal generated favourable conditions for reform (Hacker 2002; Carpenter 2012; Skocpol and Jacobs 2012). In other words, in responding to particular circumstances and strategies, health reforms might overcome institutional resilience to enable change. It is clear that an assessment of the feasibility of health reform must consider institutional settings as well as the interaction between actors and strategies. The transition of the political regime from authoritarian or dictatorial to democracy is often recognised as a critical juncture that could accelerate the

implementation of radical reforms. Moran (1995, 778) makes the point about different contexts of decision-making saying that "at the centre of health care policy making is an intense distributional struggle to control the many resources allocated by health care systems. That contest occurs even in non-democratic systems, but the organisation of pluralist politics allows it to be pursued openly."

2.3 DEMOCRATISATION AND POLICY LEGACIES: IMPLICATIONS FOR HEALTH REFORMS

Scholars studying health policies claim that the transition of political regime opens up a window of opportunity for introducing reforms, and also sheds light on the various factors inherited from previous authoritarian or dictatorial regimes that influence the course of reforms (Guillen 2002; Wong 2006; Haggard and Kaufman 2008; Mares and Carnes 2008; Falleti 2010; Carbone 2012). The literature departs from the procedural distinction between the authoritarian period and the democratic regimes. According to Bunce (1995, 88), one of the characteristics shared by authoritarian states in Southern Europe, Latin America, and Eastern Europe is that "all featured limits on civil liberties and concentration of political power in the hands of leaders who were not held accountable to the people by means of competitive elections." In contrast to this, democratic regimes are defined as "a set of institutions that, in the context of guarantees of political freedoms, permits the entire adult population to choose their leading decision-makers in competitive, honest, regularly scheduled elections" (Weyland 1996, 8). The new democratic scenario is embedded in an open electoral competition; therefore, it delineates how social actors can get access to the decision-making process. It also outlines who can get access, how actors put their demands into the public agenda, and how policy makers respond to them.

From the historical institutionalist approach, the concepts of policy legacies and path dependency are central to explaining the outcomes of social policy reforms in the context of democratisation. This literature examines how the structures and institutions created under authoritarian regimes affect the capacity of actors to influence the policy process (Guillen 2002; Castiglioni 2005; Jordan 2009; Roberts 2009; Ewig and Kay 2011; Aspinall 2012). Thus, the question is how do legacies from authoritarian regimes affects health policy reforms in newly democratic countries?

In explaining the feasibility of health policy reforms, scholars give attention to two dimensions of policy legacies. First, the direction of the reforms and who is affected by the initiative; and second, the institutional framework and its impact on health sector decision-making (Bonoli 2001; Swank 2001; Kaufman and Nelson 2004; Pribble 2013). However, studies show irregular patterns in the inclusion of new actors in decision-making and how the integration affects the implementation of health reforms after the political transition.

2.3.1 Direction of reforms and political participation

In determining the direction of reforms, scholars have examined the transformation of health systems in former authoritarian countries, noting that health reforms may adopt different paths depending on the aims to be addressed (e.g. financial constraints, managerial issues, or redistributive objectives): privatisation, universalistic systems, or an intermediate option (Kaufman and Nelson 2004; Haggard and Kaufman 2008). For instance, studies on the health sector in Latin America, show that while some countries introduced changes toward market-oriented systems (such as Argentina and Peru), countries like Uruguay have mainly developed policies to maintain their universalistic systems (Castiglioni 2005).

The content, aims, and direction of health policy reforms are essential to understanding their feasibility, as they define who is involved and what political struggles are expected. Cutbacks in social programmes that were previously based on principles of universalism (i.e. free access to health services) are more unpopular within civil society as the citizenry as a whole was directly benefiting from the existing conditions. This was the case in post-authoritarian countries with extensive public health systems that, after the regime change, underwent, as a result of austerity plans, a reduction in universalism. Studies conducted by Haggard and Kaufman (2008) and Roberts (2009) agree that the privatisation of health care was difficult to accomplish in Eastern European countries. The state-owned system from the communist years (known as the Semashko model) created constituencies willing to defend the entitlement of free healthcare services for the all, although there was a lack of quality and efficiency in the universalistic system as health workers and professionals observed it. Thus, despite the history of entitlements, in almost all the former communist countries, reforms were on the political agenda after the regime transition but implemented at different paces (Roberts 2009).

Meanwhile, the expansion of centre-left governments in Latin America in the 2000's, known as the new left[5], boosted the expectations of citizens by promoting an agenda of universalistic social policies (Ewig and Kay 2011; Gideon 2014). However, evidence from political economy studies has shown that not all of the leftist governments have pursued expansionist plans, as the country-specific characteristics, historical features, and economic contexts restrict the implementation of policy reforms (Haggard and Kaufman 2008; Levitsky and Roberts 2011; Flores-Macias 2012; Huber and Stephens 2012; Pribble 2013).

For instance, in most post-authoritarian countries in Latin America and some Southern European countries, in which national health systems have been built or reformed on the basis of liberal principles, the private sector is a strong player, in a context where market rules have largely benefited wealthy entrepreneurs giving them control of economic and political resources. Guillen (2002) presents contrasting cases in the reforms of Portugal and Greece, which have moved towards universalist healthcare systems. In these countries, even though there was a significant portion of private entrepreneurs in the health sector before the transition, they did not block reforms in the new democratic period. However, these groups hindered its implementation after reforms were enacted. One external factor that could have affected the health reforms in these cases (that could also be applied in a different way to Eastern European countries) is the motivation of the private sector to achieve the standards required to join the European Union (EU). Private sectors' entrepreneurs would be interested in reaching consensus with governmental authorities and would not block the accession to the EU by showing internal struggles, but would obstruct implementation to ensure their interests were not affected. The case of Chile is paradigmatic of the private sector involvement that will be further explained in the next section.

With respect to medical associations, it is commonly accepted that doctors have particular assets concerning information and knowledge. Medical associations place them in a network of contacts comprised of political and economic elites that puts them in a favourable position to get access to decision makers (Starr 1982; Roberts 2009; Carpenter 2012). The importance of

[5] Néstor Kirchner (Argentina 2003), Luiz Inácio Lula da Silva (Brazil 2002-2006); Evo Morales (Bolivia 2005), in Chile, Ricardo Lagos (2000) and Michele Bachelet (2006 and 2014 respectively); Rafael Correa (Ecuador 2006); Hugo Chávez (Venezuela 1998), and Tabaré Vásquez (Uruguay 2004).

doctors in the context of health reforms depends on several factors, such as: to what extent they can use their power to block or support the process, the reforms' content, and whether they are engaged in private or public sectors or in both. For example, if the proposal intends to regulate medical practice or increase existing regulations, doctors associations would be likely to oppose it. This would lead to a series of strategies, such as national strikes or public campaigns, intended to pressure decision makers to reverse the proposal (Kaufman and Nelson 2004; Kwon and Reich 2005). However, following Immergut's arguments (1990, 1992) the power and influence of medical groups are still framed and shaped by institutions; which varies for instance, if professional associations are formally included to participate in Ministerial boards on national policies, or if there is citizen legal initiative that permits interest groups to propose laws.

Some cases show that due to repression and limited participation, organisations such as doctor's associations and health worker unions lost power during authoritarian regimes. In the case of Chile, healthcare unions that had previously played important roles in the expansion of social policies were banned by the Pinochet regime. Even after the regime transition, labour organisations that were dismantled during the dictatorship did not fully recover and lost the veto player status they had before the breakdown of democracy (Roberts 1998; Castiglioni 2005).

In post-authoritarian countries, relationships between health sector unions and leftist parties can be expected to vary from those in advanced industrialised countries that have not experimented with authoritarian regimes. The nature of the relationships in the latter have been elaborated by power resource scholars (Esping-Andersen 1990; Korpi 2001; Huber 2001) who suggest that the expansion of social policies is a result of the collaborative ties between unions and centre-left political parties. However, this body of knowledge fails to explain those cases where labour groups are not formally institutionalised, or where leftist political parties are not attached to the aims of workers. For instance, scholars note that some Southeast Asian countries that effectively introduced universalistic social policies were characterised by weak unions and left-wing parties (Kwon and Reich 2005; Wong 2006; Haggard and Kaufman 2008; Mares and Carnes 2008).

On political participation, the link between democratic regimes and citizen involvement, as a *per se* dynamic from the political regime change is, at best, mixed, as several political historical accounts show different results. For instance, after the change of political regimes, in the majority of Latin American countries health reforms were conducted in a top-down manner rather than

through an inclusive process. Indeed, health policy reforms have mostly been implemented following governmental proposals without public debates or open participation (Kaufman and Nelson 2004; Mesa-Lago 2005). In this line, some studies refer to the role of bureaucrats and public employees as a team that provides technical support for policy-making and play an important role, because the autonomy of civil servants shields them from political polarisation (Gonzalez-Rossetti and Bossert 1999; Gonzalez-Rossetti 2001; Kaufman and Nelson 2004; Wong 2006; Roberts 2009; Dargent 2012). The strongest teams in charge of the reforms within the bureaucratic apparatus are found in Latin America, where they constituted a significant force for promoting change and challenging opponents of the reforms, and based on technical knowledge and skills, are critical in understanding the processes of case studies in this region (Kaufman and Nelson 2004). The analysis of these technocratic groups within the governmental apparatus in post authoritarian countries takes into account that some of them were actually following the orientations of the international organisations that were pushing forward cost-efficiency mechanisms and the out-sourcing of public services, in the context of the Washington Consensus based on guidelines of the World Bank Report of 1993. Analysing pensions and health reform, Weyland (2006) adopts the concept of policy diffusion for the dissemination of the neoliberal reforms in Latin America, and other studies highlight the importance of the spread of principles and norms facilitated by the globalisation, which connects the "role of ideas" with the concept of policy diffusion (Weyland 2005; Mares 2009; Linos 2011). International Institutions such as the International Monetary Fund, World Bank or the Inter-American Development Bank appear as actors with a fundamental role in understanding the wave of structural reforms which took place in Eastern Europe and Latin America from the 1980s onwards, taking into consideration their capacity to impose conditions for the obtaining of credit (Bresser Pereira et. al 1993; Stallings 1993). Although these strategies has been explore for the cases of Latin America scholars suggest to be cautious about the direct implication of the international organisations as drivers for policy reforms; as the national and internal situation of the countries still matters in to determine the feasibility of policy reforms (Lloyd-Sherlock 2005; Nelson and Kaufman 2005; Weyland 2006).

In contrast to stronger groups of technocrats, weak and unprepared teams are more likely to be influenced by interest groups or pressures from outside the government. This happened in one of the Eastern European countries examined by Roberts (2009). The author presents the case of the Czech Republic, where many experts occupying bureaucratic positions were purged from the public administration under the authoritarian period. When the newly democratic governments

started to restructure the health system, they used an unprepared bureaucracy which delegated the development of the reform plan to medical experts outside the government.

The Brazilian and South Korean cases present contrasts to the top-down reform after regime change. For instance, and unlike in the authoritarian years, the health reforms in democratic South Korea integrated civil society groups into the decision-making process. Kwon and Reich (2005), and Wong (2006) explain that health reforms in the late nineties were embedded in a bottom-up process. The authors describe the formation of the Health Solidarity Coalition, comprised of 80 social movements groups (i.e. broad cross-class groups, including unions, the middle class, professionals, academic experts, and rural populations), that built connections and ties with governmental authorities to push for an integration of medical insurances. Wong (2006) suggests that two main aspects permitted the approval of the reform in South Korea after the political regime change: this transversal organisation of civil society groups with experts in the area; and a government with leadership and central authority willing to respond to the civil society demands.

The Brazilian case is different from other Latin American countries as the universalisation of health, a bottom-up process, was prompted by actions taken during the authoritarian years, and was completed during the democracy (Arretche 2004; Falleti 2010). According to these authors, the military (1964-1988) carried out various initiatives to co-opt the rural population, for instance, permitting elections for regional authorities, or implementing progressive health programmes in areas where they had little control, as strategies to legitimize the government. These plans allowed the *Sanitaristas* (leftist medical activists) members to reach relevant positions within public administration, "infiltrating the state" and developing a pro-universalism agenda. All the cases reviewed above confirm the various patterns regarding directions of health reforms and participation in post authoritarian cases.

2.3.2 Veto points: implications for health sector reforms

The factors that influence the direction of health reforms and the actors involved depends directly on the institutional framework in which they are embedded. In this way, a great deal of studies on health policy reforms have considered the implications of constitutional frameworks and the distribution of policy-making authority that emanate from them. For instance, the effects of the

type of regime, the organisation of government (federal or unitary), electoral systems, legislative mechanisms, and the degree of state's involvement in the provision of health have all been studied (Immergut 1992; Huber et al. 1993; Bonoli 2001; Castiglioni 2005; Jordan 2009). In this sense, constitutions demarcate the scenarios and mechanisms within political systems in which health reforms can be authorised, thus converting these arrangements into veto points for policy change. The general assumption is, the higher the number of veto points, the more obstacles to reform (Immergut 1992; Bonoli 2001; Roberts 2009). Following Lijphart's (1999) distinction, presented in a previous section of this chapter, most Latin American countries are consensual–presidential regimes with some variations, for instance federalist vs. unitarian structures, or electoral systems. The implications of the dispersion of power between the executive and legislative branches, of presidential regimes versus parliamentarian, unicameral or bicameral legislative bodies, and electoral system are analysed in some studies on health reform in post-authoritarian countries (Kaufman and Nelson 2004; Castiglioni 2005; Pushkar 2006).

Issues tackled in the literature, such as the presidential powers to authorise health policy changes (e.g. decrees, urgencies, budgetary controls, to initiate reforms without the authorisation from Congress) determine to what extent the president requires the support of legislators. The literature suggests that health reforms led by executive branches would be easier in countries where the leader of the government is elected by parliament. In this case, she or he could count on the support of legislators to implement their political agenda (Bonoli 2001; Kaufman and Nelson 2004; Scartascini 2011). Nevertheless, studies of health reforms in South Korea (Kwon and Reich 2005; Wong 2006), Brazil (Arretche 2004) and Chile (Olavarria 2011) report that where the president has ample prerogatives in policy making, his or her role and degree of involvement in the process of implementing the health reform has been key. Kaufman and Nelson (2004), from a comparative examination of health reforms in Latin America, suggest that legislative bodies were less important than presidential leadership and their commitment to the reform. Although some cases show that deliberation within the Congress was an important part of passing the health reforms bill (for instance, in Colombia), most successful initiatives responded to the presidents will push the reform (Ramirez 2004).

In relation to mechanisms for participation, similar to the case of Switzerland explained by Immergut (1990, 1992), in Brazil and Colombia referendums and Constituent Assemblies permitted the involvement of people, allowing them to formally push their initiatives forward. Both Latin American examples show that the achievement of redistributive goals in the health sector was

permitted by mechanisms that promote a wider participation of actors (Arretche 2004; Ramirez 2004). Federalism and decentralisation have also been part of studies on health sector reforms due to their effects on the aggregation of interests. Both factors distribute the control of resources and delegate decisions to regions, empowering autonomous actors to fight against central governments (Guillen 2002; Kaufman and Nelson 2004; Jordan 2009; Falleti 2010). Federalism, according to Falletti (2012), played various roles in the Brazilian universalistic health reform. It put some reformers in local and national positions to facilitate a bottom-up process, it extended the influence of political parties to the local land state levels, and also an increased interest of regional authorities to build networks with governmental and legislative branches.

Table 1: Factors considered by the literature on health reforms in post authoritarian countries

Direction of reforms and political participation	Content and emphasis of reforms
	Procedures and degrees of participation (who and how): bottom up/top down; technocrats, civil society representatives, medical associations, unions.
Veto points and veto players	Veto points refer to institutional rules that creating incentives and constraints, while veto players are actors which agreement is essential in the decision-making.
Policy legacies	Constitutional norms, informal rules and procedures Constituencies.

Source: own elaboration

2.3.3 Policy legacies and veto points in Chile

Several studies on health policy change in Chile have looked at the institutional veto points and veto players to explain the stickiness and inertia of the political and economic model after the return of democracy (Gonzalez-Rossetti et al 2000; Castiglioni 2005; Davila 2005; Pushkar 2006; Ewig and Kay 2011; Pribble 2013). According to these studies, health reforms implemented since 1990 were mostly incremental due to policy legacies inherited from the authoritarian years. In 1981, Pinochet sought to consolidate the regime through a new constitutional framework, which was

implemented using fraudulent procedures, that was sanctioned through a vote on September 11, 1980[6] (Varas et al. 2012; Fuentes 2013). This text established the political and administrative organisation and also contained a number of ad-hoc laws that regulated civil society participation under the authoritarian context. Before he passed control of the government to the new authorities in 1990, there were some, widely agreed, changes made to the Constitution. Both the enactment of the 1980 Constitution and the amendments of 1989[7] are known as "authoritarian enclaves" (Garreton 1995), established by Pinochet to define the formal distribution of power and the rules of governance that limited the road of democratisation. In relation to the existing literature, the key veto points and policy legacies from the Constitution and additional "authoritarian enclaves" are explained below.

One of the focuses of the analysis of Castiglioni (2005; 2006) was in the understanding of the feasibility of health policy reforms is the distribution of power among authorities. It has been argued that the President has prerogatives that exceed the legislative faculties of the Congress (Dockendorff 2011; Luna 2014). Specifically, the executive has the exclusive legal initiative on issues related with budget, collective bargains, social security laws, and new public institutions. In the same vein, the President is entitled to veto those legislations proposed by the Congress' representatives, and also to modify the timing of the legislative agenda, introducing legislation or decreasing the urgency needed for discussion. Additionally, all the issues related with public budget are controlled by the Executive giving the president the most important role in the decision-making process.

A second arrangement is the minimum of votes required in the Congress for policy change, which depends on the type of laws that ranges from absolute quorum, for instance, law regarding national security or civil rights; to those ordinary laws that just need the minimum number of

[6] Claudio Fuentes (2013) in his book "El Fraude" (The Fraud) presents an in-depth analysis of the ambiguous circumstances that surrounded this plebiscite.

[7] In addition to the constraints posed by the legal framework, a subset of organic constitutional laws were enacted in the last days of Pinochet's regime, that, due to the quorums stated in the Constitution, could not be reversed unless approved by 4/7ths of Congress. These laws, known as the "Binding Laws" (*Leyes de Amarre*), became a straitjacket for later authorities. For instance, an educational law (*Ley Orgánica Constitucional de Enseñanza*- LOCE) and the penalization of the abortion (which was permitted in Chile since 1931) were enacted (Valenzuela 1997; Taylor 2006; Angell 2007; Fuentes 2010; Varas 2012).

congress representatives present in the legislature (Fuentes 2010; Garreton and Garreton 2010). Constitutional changes –to actually change these rules– require higher quorums. These include reforms on aspects such as the electoral system, public administration, and constitutional courts, among others.

The third institutional arrangement mentioned in the literature, is the role of the designated and for life senators. Ex-presidents could become senators (so Pinochet could get a seat); and the designated senators were ex-commanders for each armed, navy, air, and police force. 3 representatives from the Supreme Court (two ex-ministers and the National Comptroller) and two senators nominated by the president, one a former university provost and one ex-minister (Fuentes 2010; Garreton and Garreton 2010). The aim in including these senators was to ensure that there would be no majority in Congress to give the armed forces a place in the legislative process, and to counterbalance the executive power.

The last institutional arrangement frequently tackled by the literature as an obstacle for policy change, is the electoral system. Congress' representatives are elected by a proportional representation system with a D'Hondt formula of two-member districts for both chambers. Each political party or coalition nominates two candidates in an open list, to choose one. The one with the most votes gets one seat, while the second seat goes to the candidate with the most votes from the second list, unless the second candidate from the same party or coalition as the first majority gets double the votes. That means that even if the second majority obtains just 33,4% of the vote, he or she can be elected even though the second most voted candidate from the opposite list has more votes than 33,4%. As a consequence, in many districts there is one representative of the centre left bloc and one from the right (Cabezas and Navia 2005; Aninat 2006). Other implications from this system is that the elites have control of the appointments of candidates, as each bloc is decided in advance as to who is the strongest candidate to ensure at least one seat, and outsiders have little chance to get the minimum number of votes.

Informal legacies are also discussed in the literature. Studies have emphasise that informal connections in Chile society are strongly marked by the concentration of small groups of power people because their socio-economic background. In particular, the intensification of wealth concentration in an economic elite, most of them benefited from events such as the Land Reform under Salvador Allende Government in the 70's (*Reforma Agraria*); the sale of state-owned industries after the democratic breakdown (buying shares of public enterprises in non-transparent

transactions) and from the internalization of the economy since 1990 (Monckeberg 2001; Undurraga 2011). Societal structures have replicated the configuration of elites by friendship and familiar ties, which are extremely important when it comes to decide where elites' children are educated or with whom to make business, favouring endogamic relationships (Thumala 2007, Undurraga 2011). For instance, politicians, entrepreneurs, and academics have attended to a specific range of schools, most in the capital of the country, with a certain political and religious profile. As a demonstration of this, two studies illustrate that the Chilean legislators shares a very similar educational background and the majority of them studied at the San Ignacio School (*Colegio San Ignacio)* founded by the Jesuits Congregation (Espinoza 2010, Joignant and Navia 2003), sharing a network of professional contacts built in the school years.

Since the return to the democratic regime in 1990, the business elite became a major player in the decision-making process as they supported right leaning views, through the linkages between these business groups and right-wing political parties (Fairfield 2015)[8]. Religiosity is another important characteristic that bonds these groups, mainly to the right leaning elite, as they belonged to different sects of the Catholic Church (i.e. Opus Dei, Legionaries of Christ and Schoenstatt), creating a network of wealthy, right-leaning, and Catholic devotees (Varas 2012) who influenced the decision-making process according to their values.

As the combination of economic, religious, and political power was a characteristic from the right, while the more lefitest group, were no confessional, some of them with owners of companies of members of boards in different companies, and formal political power as various them were working in governmental positions. The Chilean author Cortes Terzi (1997) called "the extra-institutional circle of power" which shares knowledge and have difference levels of influence given their privileged position in the Chilean society as decision makers within and outside the governmental positions.

Previous studies have examined the political processes of health reforms in post-authoritarian Chile, tackling the effects of the institutional arrangements from various angles. One such case is the work of Castiglioni (2005; 2006) that observed the concentration power in the president's

[8] In her book, Fairfield (2015) explores, in detail, the consequences of business group involvement on the outcomes of taxes' reforms in Argentina and Bolivia and Chile.

hands as it has been recognised as a key feature of the Chilean political system. In contrast, she argues that despite the prerogatives of the executive authority defined in the Constitution, due to the binominal electoral system, presidents in Chile generally do not count on a clear majority, as there is a draw of the two main electoral blocs, *Alianza* and the *Concertacion.* In other words, the distribution of seats in the congress implies that several negotiations between the executive and legislative branches are needed to push bills forward, diluting presidential powers (Castiglioni 2005, 2006; Pushkar 2006). In the study of the Lagos reform, Castiglioni (2006) also indicates that designated senators increased the minimum votes required to approve the bills, preventing further policy changes as most of these senators permanently supported right leaning viewpoints.

Also giving attention to the congress but looking at the political parties' behaviour, Davila (2005) and Pushkar (2006) argue that internal conflicts within the Christian Democratic Party between conservatives and progressive factions affected the course of the health reforms, shaping the final outcome within Congress. Davila (2005) suggests that the conservative standpoints of relevant congressional representatives from this party obstructed the governmental plans as they disagreed on the funding methods proposed for the reform. Using their political advantage within the *Concertacion,* they pressured the government into modifying the original proposal, cutting down the most controversial issues about the economic resources, and then moderating the final results of the reform. Additionally, since 1990, an informal procedure adopted between political parties within the *Concertacion* is pointed out by Siavelis (2016) in the process of designation of authorities in ministries and undersecretaries, which is widely known a *"cuoteo"* in the distribution of these positions that became a particular strategies to distribute power in a multiparty system. This *"cuoteo"* was the process in which the nomination of a minister who was a militant of one party from the *Concertacion,* for instance, a Christian Democrat; was necessary complemented with a nomination of an undersecretary of a different party from the bloc for example, the nomination of a Socialist Party member to maintain the political equilibrium between parties. According to Siavelis (2016) authorities nomination was perceived not as a meritocratic process, instead was an informal arrangement to keep the political power controlled by the elites parties, as people nominated were not always professionally prepared to assume that position.

Slightly in contrast with the above, Ewig and Kay (2011), and Pribble (2013) suggest that despite the remaining institutional legacies, the two last governments of the *Concertación* led by Ricardo Lagos (2000-2006) and Michelle Bachelet (2006-2010) have introduced substantial –but still incremental– changes in the health and pension sectors. These authors note that these sets of

reforms should be understood in the context of the spread of the new left in Latin America, in which politicians promoted expansionist social policies. However, the post-retrenchment or post neoliberal reforms are largely mediated by domestic politics, which shape the scope of changes introduced by each government.

For instance, scholars point out that due to a privatisation of social policies under the Pinochet's dictatorship, private insurers and providers in the health sector introduced during the eighties became veto players in the democratic period. Specifically, Ewig and Kay (2011) confirm the incrementalist character of the Chilean political system based on the involvement of the private sector and the weakening of civil society under Pinochet imposed several constraints for Lagos, due to the strong ties of these private actors to right-wing politicians, which represented the best option for status quo in the political debate, ensured this (Gonzalez-Rossetti et al. 2000; Castiglioni 2005; Ewig and Kay 2011; Fairfield 2015). Pribble (2013) examines the discussion of the Chilean health reform looking into what extent the Lagos initiative guaranteed coverage of all citizens. Based on the role of political parties and their internal organisation, Pribble (2013) argues that the Lagos's health reform was a significant attempt towards universalism, in the end, it was a limited policy reform as it did not achieve the goals in providing the levels of coverage expected.

Altogether, the scholarly literature on Chile emphasises the inertia of the health sector after the return to democracy which fits more closely to the arguments of historical institutionalism and veto points. According to these arguments, due to the institutional resilience of the political system, any reform is constrained by the stickiness of policy legacies and path dependence and is likely to have limited impact. In that sense, it is important to understand how and why this healthcare reform was achieved within the incrementalist Chilean political system. How did the consensus style adopted by post-transitional governments enable policy change in the health sector?

While some studies have been explored, the implications of the institutional factors to confirm the stability and limited change, the interaction of actors embedded in this context and strategies employed to foster change have been less explored. Furthermore, extant literature also opens a question about the meaning of change, or more precisely, what sources facilitate policy change and what the extent of the transformation is. Following the studies of Hall (1993), Streeck and Thelen (2005), Mahoney and Thelen (2010), about gradual institutional change, Ewig and Kay (2011), and Pribble (2013) refer to the outcome of the reforms as incremental universalism or layering change due to policy legacies. Nevertheless, recent studies of policy change look at

alternative theories to explain why some countries succeed in reforming their health sectors in spite of the weight of institutions, and go beyond the binary scenario of incremental or non-existent change (Studlar and Cairney 2014). This is very much in line with the suggestions from Peter Hall (2010) regarding the necessity to integrate additional perspectives to the institutionalist analysis of policy change, specifically from a sociological approach and rational choice theories. While his recommendation did not explicitly mention theories of public policy, he suggests the analysis the policy process as a contention of power between actors within the institutional frame to improve our understanding of policy change. Precisely, in the next chapter I assess alternate theories that contribute to a more comprehensive picture of the policy process and the sources that drive for policy change, providing a detailed explanation of the theoretical framework of my thesis.

2.4 SUMMARY

This chapter reviewed the main theories, concepts, and dimensions employed in the analysis of health reform, focusing on those studies concentrated on post-authoritarian countries. Within the extant literature, the historical institutionalist approach is often used in explaining the concepts of policy legacies and path dependency, to understand the effects of previous decisions in current situations. A large number of studies have been conducted in advanced industrialised countries, emphasising "a frozen landscape" of the health systems as reformist actors' struggles are provoked by the institutional roots in each country. The second section examined the literature on post-authoritarian countries concentrating on two main dimensions: political participation and institutional veto points. Evidence from the studies indicates that despite the international processes, factors affecting the feasibility of health policy reforms in post-authoritarian contexts vary from one case to another. The last part of the chapter presented previous research about health policy in Chile, explaining the particular features of the political system as legacies and veto points inherited from the authoritarian regime. These arrangements have been recurrently considered as impediments for policy change failing to explain cases as the health reforms analysed in this research. In order to fill this gap, the following chapter presents a theory of policy change, the Advocacy Coalition Framework (ACF) elaborated within the public policy field, which is a suitable approach to analyse policy change in the Chilean health sector, beyond the historical institutional explanations.

CHAPTER 3 ANALYTICAL FRAMEWORK

3.1 INTRODUCTION

The previous chapter considers the state of knowledge on health reform processes, particularly in the post-authoritarian countries. Studies based on the Chilean case were also reviewed, identifying the gaps in the existing literature to explain policy shifts in the new democratic context. Considering the limitations of institutionalist perspectives and with the aim of overcoming stability and single events, such as causal explanations of change, the present chapter focuses on the Advocacy Coalition Framework (ACF) as a suitable approach to understand the factors that lead policy change, in spite of institutional policy legacies and path dependency effects.

The first section of the chapter begins examining the contribution of the Advocacy Coalition Framework (ACF) and its premises, highlighting its particular value for developing a comprehensive understanding of policy process. In the second section, I appraise the factors that explain policy change, providing examples from studies that have employed the framework. Lastly, I present a number of previous ACF works on post-authoritarian regimes, showing how the Chilean case helps to fill the theoretical and empirical gaps.

3.2 THE ADVOCACY COALITION FRAMEWORK (ACF)

Sabatier et al. put forward the Advocacy Coalition Framework (ACF) to take into account the interactions of actors grouped into coalitions, their strategies and their beliefs within a particular policy subsystem. It combines these factors and stable institutions with dynamic mechanisms that influence the policy process (Sabatier and Jenkins-Smith 1999, 1993; Sabatier and Weible 2007). As such, the ACF as a research programme offers a more comprehensive picture of the policy process, allowing for observations of the interaction between structure and agency, and providing an interpretative framework of the policy process that facilitates the comparison of cases, areas, and disciplines.

3.2.1 The foundations of the ACF

There are five main theoretical premises that constitute the core of the advocacy coalition framework: First, the policy process is analysed in a **policy subsystem,** which is a specific area delineated by geographical or organisational boundaries and composed of participants which aims to determine the course of the policy process (Sabatier and Weible 2007). For research purposes, different areas or sectors (i.e. education, forest, media, pollution, or health) can be defined as subsystems. It should be noted that these policy subsystems may be at the national, local, or transnational level[9] (Carboni 2012).

Secondly, within the policy subsystem, there are **coalitions**, composed of individuals, groups, or organisations that interact regularly, and seek to influence the decision making in the domain of interaction (Sabatier and Weible 2009). The idea of coalitions, which generally range in number from one to four, is a distinctive feature of the ACF and distinguishes it from approaches focused on state authorities (e.g. institutional perspectives), or those theories that put the individual at the centre of the analysis (e.g. rational choice approach). Coalitions may include an array of actors, which, depending on the policy domain under study, includes governmental officials, interest groups, political parties, civil society representatives, researchers, and journalists. In this approach, the definition of actors goes beyond formal positions, including people located outside the policy

[9] Such as topics related to globalisation processes or the political process at the European Union level.

subsystem that might get involved in the process. This innovative consideration about whom is involved in the policy subsystem activities differs from other theories such as the rational choice, as in the ACF actors interacts frequently in different degrees and extents within coalitions and not individually guided in formal and informal positions of power. Jenkins-Smith et al (2014) points out the conceptual distinction between principal actors (who are central and consistent members) and the peripheral actors (who are not regularly involved in coalitions activities). In this line, Howlett (2010) presents a table of public and non-governmental actors that are involved in policy processes:

Table 2 Actors in policy processes

Actors	***Public governmental sector***	***Non-governmental sector***
Core actors	Central agencies and task forces	Consultants, political parties staffs
	Professional governmental policy analysts	Pollsters, donors
Peripheral actors	Commissions, committees	Public interest groups, business associations, trade unions
	Research councils, scientists, international organisations	Academics, think tanks, media, International NGO's

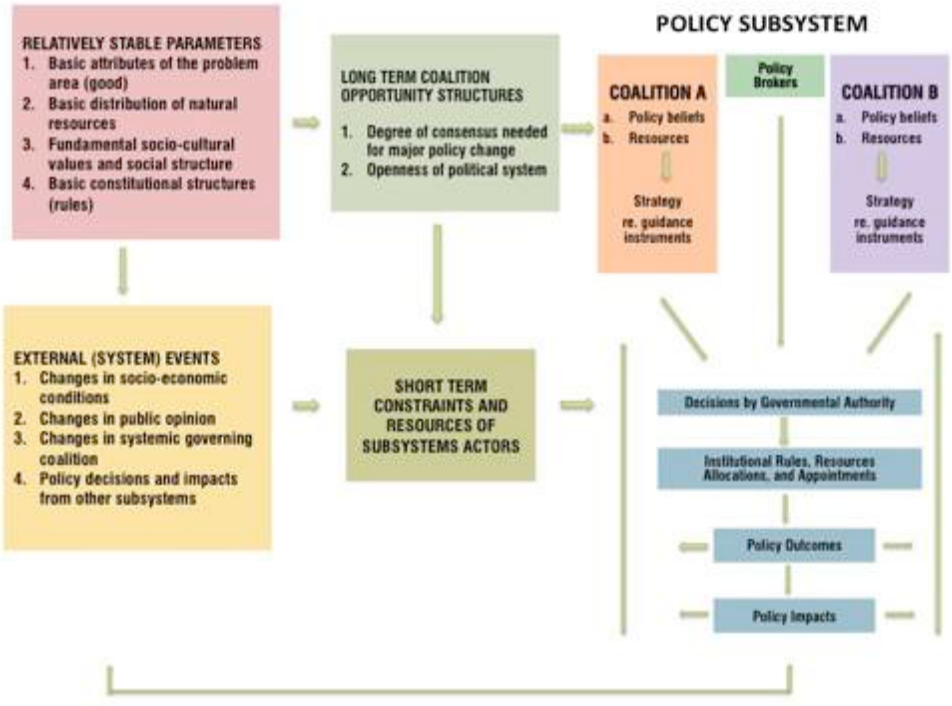
Source: Adapted from Howlett, M. 2010.

The third premise of the ACF is that members form coalitions because they share **beliefs and common values**. Furthermore, they possess similar views about what issues must be solved and what the best alternatives for dealing with those issues are. These beliefs are framed in a hierarchical system that goes from wide normative principles (like views about human nature), to the translation of these principles into policy solutions (i.e. market vs. state regulation), and on the third level, to instrumental policies. One of the advantages about to organise the different types of core and peripheral actors in coalitions, is the simplification for its study as the wide array of people involve can be grouped and analysed in groups that share some beliefs, values and activities to be analysed by scholars. Among the challenges of the framework, is helping to researchers is to understand how and why these individuals coalesce and to what extent they have coordinative activities that might stimulate policy change.

Fourth, this framework claims that the interactions in a particular policy subsystem have to be understood in a **long-term perspective** (over a decade or more), from the point when coalitions form to the moment they interact regularly. This process, which is cumulative, may take a decade or more. As this premise could be interpreted as a rule that prevents studies focused on shorter periods, it has been clarified by Jenkins-Smith, Norhrstedt, Weible and Sabatier (2014) that there is no limitation into applying the ACF in policy process of less than ten years period, which it would depends on the research question and theoretical emphasis of the investigation.

The fifth point refers to the role of **technical information**. Since the complexity of any policy subsystem requires long term commitment and specialisation, technical knowledge and scientific expertise provide support and legitimacy to coalitions' views and opinions. In this case, the ACF emphasises the role of scientific communities and experts as advisors within political subsystems. These premises of the ACF model are presented in the next diagram, which can be separated into two parts. On the right side is the policy subsystem based on the core principles of the ACF, and the left side shows the factors of the general political system in which the subsystem, the health sector in this study, is entrenched. This will be explained in more detail in the next section.

Figure 1 ACF Flow Diagram of the policy process



Source: Sabatier and Weible (2007).

3.2.2 Stable parameters and opportunity structures

The interaction of coalitions within the policy subsystem is embedded in a scenario comprised of stable parameters and dynamic factors, which are simultaneous constraints and resources for the actors involved. Stable parameters, such as the characteristics that shape the values and rules of a society, are less likely to change over time. This can be seen as the general context for the political system that defines how the problem area is conceived, how natural resources are distributed, and what the rules and norms that determine the boundaries for interaction are (Blank and Burau 2010; Gupta 2012; Fisher 2014).

The ACF also identifies a category of “opportunity structures" as part of these external features and was developed as a response to the critique that the ACF used the US institutional framework as its analytical background. This concept allows the application of the framework to countries with different political systems by including two interrelated dimensions: the openness of a political system, and the degree of consensus needed for major policy change (Weible and Sabatier 2007). Both dimensions are linked with Lijphart’s classification (1990) of democracies (see Chapter 2) regarding to the dispersion of political power and the majorities required to change the status quo. It is based on the idea that the higher the number of veto points, the more barriers there are for policy change. For instance, in majoritarian systems that have a dominant party in government, the number of formal veto points is lower than in countries with multiparty alliances in government. According to Weible, Sabatier, and Flowers (2008) the differences in the consensus required and the number of accessible venues for influencing the policy process determines the configuration of coalitions and the degree of their participation in the decision-making process. As such, the ACF does not neglect the institutional arrangements presented in the historical institutional literature in previous chapters.

3.2.3 Coalition beliefs systems

The core idea of the ACF is that coalition members hold particulars views and beliefs that determine their actions and decisions. This is unlike other approaches, such as rational choice that assumes that an individuals’ behaviour is strictly motivated by self-interest and the maximisation of benefits (Sabatier and Weible 2007). Instead, in the ACF, driven by common interests, individuals share beliefs and work together. These common interests are then translated into strategies

designed to achieve a coalition's goals in a particular policy subsystem (Zafonte and Sabatier 2004). According to this model, there are three levels of beliefs: deep or normative core, policy core, and secondary aspects. While the first category of beliefs consists of a set of views based on general principles or cleavages (left-right/, conservative/liberal), the policy core is the position of actors on the policy subsystem under analysis. The secondary aspects are the instruments that translate policy core beliefs into decisions within the subsystems. The next table presents the distinctions between different levels of beliefs:

Table 3 Belief systems

	Deep (Normative) Core	Near (Policy) Core	Secondary Aspects/Instruments
Defining characteristics	Fundamental normative and ontological axioms	Fundamental policy positions concerning the basic strategies or achieving normative axioms of deep core beliefs.	Instrumental decisions and information searches necessary to implement policy core.
Scope	Part of basic personal philosophy. Applied to all policy areas	Applies to policy area of interest (and perhaps a few more).	Specific to policy area/subsystem of interest.
Susceptibility of change	Very difficult; akin to a religious conversion	Difficult, but can occur if experience reveals serious anomalies	Moderately easy; this is a topic of most administrative and even legislative policymaking
Illustrative components	The nature of man: Inherently evil vs. socially redeemable. Part of nature vs. dominion over nature. Narrow egoists vs. contractarians. Relative priority of various ultimately values: freedom, security, power, knowledge, health, love, beauty, etc. Basic criteria of distributive justice: whose welfare counts? Relative weights of self-primary groups. All people, future, generations, non-human beings, Socio- cultural identity (ethnicity, religion, gender, professions)	Proper scope of governmental vs. market activity Proper distribution of authority among various unit (e.g. levels) of government. Identification of social groups whose welfare is most critical Orientation on substantive policy conflicts e.g. environmental protection vs. economic development. Magnitude of perceived threat to those values. Basic choices concerning policy instruments, e.g. coercion vs. inducement vs. persuasion. Desirability of participation by various segment of society: Public vs. elite participation Experts vs. elected officials Ability of society to solve problems in this policy area: Zero-sum competition vs. potential for mutual accommodation Technological optimism vs. pessimism.	Most decisions concerning administrative rule, budgetary allocations, disposition of cases, statutory interpretation, and even statutory revision. Information concerning program performance, the seriousness of the problems, etc.

Source: Sabatier (1993, 31).

A crucial feature of the ACF is the assumption that the first level, normative beliefs, is the most difficult to change. Rival coalitions might perceive and interpret the same issue in quite different ways because they have polarised frames of references. This is the basis for competition within the ACF framework. People within coalitions tend to filter and process information according to their beliefs, remaining relatively stable over the years. Nevertheless, the second and the third

levels of beliefs are more susceptible to change. For example, new information and knowledge can modify coalition members' perceptions on the policy subsystem. Instrumental decisions or secondary aspects of beliefs systems, which may differ within a coalition, are more likely to be adaptive, as actors may be willing to make concessions in order to achieve solutions to specific problems. Derived from this classification of beliefs, is an understanding of the degree of policy change. The ACF postulates that major policy change occurs "as a change in the policy core aspects of the policy subsystem, and minor policy change [takes place] as a change in the secondary aspects of the policy subsystems" (Weible, Sabatier, and Flowers 2008, 3). The distinction of levels of policy change is the particular interest for this thesis, as it provides a point of reference in assessing to what extent coalitions' belief systems determine the feasibility of health reforms.

3.2.4 Power and coalitions resources

In a scenario where institutions, ideas and power are interconnected, advocacy coalitions deploy power and resources to shape the policy process in their favour. The potential use of these resources is primarily connected with the concept of power, which can be understood in two ways. First, it is about how power can be effectively exercised over other actors; and second is the ability to control specific assets (money, social positions, information for instance) in order to achieve the desired outcome (Buse et al. 2005). As the former is concerned, many have argued that power constitutes the basis of the political dimension of health policy (Walt 1994; Moran 1995; Oliver 2006) as such, it is worthwhile elaborating on the discussion about how power is exerted, with what aims and with what consequences.

According to the contributions of authors such as Dahl (1957), Bachrach and Baratz (1970) and Lukes (1974), power can be analysed on different dimensions. The unidirectional dimension of power is illustrated in Dahl's definition (1957) which says that power is a process in which A uses their resources to compel B to do something they would otherwise not do. This definition emphasises the dominance of one party over another. In this scenario, all actors' preferences are in the same position to determine the course of the policy process, but the outcome reflects the superiority of one actor's interests. Bachrach and Baratz (1970) draw attention to an additional

dimension: the capacity of actors to determine what issues are important in the public agenda and leave out topics that are not in their interests or that might harm the position of dominant actors. This explains why, in some cases, actors choose to not make decisions (Allison 1971). A third view of power is what Steven Lukes (1974) called 'thought control', in which the "exercise of power is constituted in the ability to manipulate and shape the wants, needs, values, and norms of behaviour of a population" (Crinson 2009, 15), and in that way, a dominant actor can oblige others to act against their will. The definitions summarised above are complementary, indicating that the concept of power can be applied in different manners. Thus, the overarching idea of these dimensions for the ACF is that political competition is a manifestation of different arrays of power and coalitions within a policy subsystem emphasising the various ways of power. For instance, it can be applied to bargaining between coalitions, coercion by one group over another, or to group compliance.

Resources are understood as the strategic asset that coalitions may use in their efforts to change existing policies. Indeed, it is how various resources are distributed in a society that determines the degree of an actor's involvement in the policy process (Nohrstedt 2011; Fisher 2014). Therefore, the success of advocacy coalitions depends a great deal on the type of resources they possess and their ability to exercise them effectively. Sabatier and Weible (2007: 189-201) outline a typology of these resources:

Table 4 ACF Typology of resources

RESOURCES	DESCRIPTION
Formal-legal capacities	Actors in positions of legal authority that may include agency officials, legislators, and judges. Dominant coalitions usually have more members in positions of formal authority than minority coalitions. Strategies for coalitions include placing allies in positions of legal authority through elections or political appointments.
Public opinion	Opinion polls showing support for a coalition's policy position. A supportive public is more likely to elect coalition supporters to legislative and other positions of legal authority and to help sway the decisions of elected officials. A typical strategy for advocacy coalitions is to spend a lot of time trying to garner public support.
Information	Information is a resource utilised by policy participants to win political battles against opponents. Strategic uses of information include solidifying coalition membership, arguing against an opponent's policy views, convincing decision makers to support your proposals, and swaying public opinion. This is one of the reasons why the ACF emphasizes the role of researchers within coalitions.
Mobilisable troops	Policy elites often use members of the attentive public who share their beliefs to engage in various political activities including public demonstrations and electoral and fund-raising campaigns. Coalitions with minimal financial resources often rely very heavily upon mobilisable troops as an inexpensive resource.
Financial resources	Money can be used to purchase other resources. A coalition with ample financial resources can fund research and organize think tanks to produce information; bankroll sympathetic candidates, thereby gaining inside access to legislators and political appointees; launch media campaigns to earn public support; and advertise their policy positions to strengthen their number of mobilisable activists.
Skilful leadership	Skillful leaders can create an attractive vision for a coalition, use resources strategically, and attract new resources to the coalition. Skillful entrepreneurs are needed to bring about actual changes in policy.

Source: Adapted from Sabatier and Weible (2007: 201-203).

These resources might be seen as a combination of assets rather than as separate tools used by coalitions to influence the policy process. After identifying actors within a policy subsystem, or coalitions according to the ACF, it is important to analyse empirically what specific resources is the determination of who is in and who is out of coalition and the ways they use these to exert their power to induce policy change. Thus, the criteria to define their role within the ACF flow diagram is assessed in terms of the availability of resources and the capacity of influence. As I mentioned in the previous section, the very definition of coalitions is that an array of actors in different positions in both public and private spheres that have joints preferences and to perform in coordinated activities, which means that there is a need to asses of who belongs to coalitions and what makes valuable to these groups in pursuing their goals in the policy subsystem. The identification of these actors are based also on the amount of economic resources and legal power via governmental positions for instance, reputational power is highly important, this is, how others perceived those individuals capacities to impose their will around the policy sector. Within the policy subsystem thought, there are additional actors that play a role differently than the pure coalitions' members in order to push forward coordination to achieve a consensual outcome. It is in this context of power competition, then that some individuals that can act as mediators on power competition (Ingold and Varone 2012), fulfilling the role of policy brokers among and within coalitions, consensual goal that puts those individuals in a different position than those who belongs to coalitions who are searching to positioning their beliefs over the others. Brokers tend to be part of administratively agencies but Jenkins-Smith et al (2014) point out that there is not a specific criteria that defines who is a broker and where comes is from; but the principal idea is that these figures have moderate positions beyond self -interest motivations looking for feasibly solutions. It is worth noting that the process of brokerage is necessarily framed in a institutional context, which determines the capacity of policy brokers to articulate and to mediate the levels of conflict within a policy subsystem, but this is a still an unexplored area of the ACF that could be further investigated taking into account the countries' opportunities structures previously mentioned (Ingold and Varone 2012; Diaz Kope et al 2013; Fisher 2014).

3.3 PATHS OF POLICY CHANGE AND ACF APPLICATIONS IN POST-AUTHORITARIAN CONTEXTS

One of the most valuable contributions of the ACF is the conceptualisation of mechanisms for policy change. Unlike other public policy theories such as the Multiple Streams and the Punctuated Equilibrium, the ACF suggests there are four paths for either major or minor policy changes. First, external events or unexpected episodes that take place outside the policy subsystem (Zafonte and Sabatier 2004). Second, internal shocks or events that take place inside the policy subsystem that may directly affect the stability of coalitions and the distribution of resources (Kübler 2001). The third mechanism, policy learning, incorporates the role of scientific knowledge and considers how the information provided by experts can promote a revision of beliefs by coalitions. This revision of beliefs may lead to policy change (Abrar et al. 2000). Fourth, negotiated agreements, which are collaborations across coalitions, in which the polarisation of the conflict is reduced and the actors involved are willing to reach a consensual agreement (Kübler 2001; Larsen et al. 2006). These paths of policy change will be explored in more detail below:

External events refer to unexpected episodes that take place outside the policy subsystem, affecting the course of the political process and the coalitions' scheme in the area under study. External perturbations may force major transformations, in which actors should be adjusting their beliefs to the new context created by the event. Some episodes, such as the election of a new government, may lead to a change in the direction of policies, or, due to the emergence of new issues like new diseases or natural disasters, to the modification of priorities on the political agenda. Sabatier and Zafonte (2004) present an example of how external events may affect policy subsystems. Their study on automotive pollution control in the US between 1963 and 1989 shows that the development of policies in this area were affected by two events: the 1973-4 oil embargo and the 1980 presidential election.

Internal shocks are events that take place inside the policy subsystem, which may directly affect the stability of coalitions and the distribution of resources in the sector. In his study, Kubler (2001), analysed the developments in drug policy (public health) in Switzerland and confirmed the idea that internal events have implications for the policy subsystem. He suggests that there was a simultaneous modification in another public health area that stimulated changes in drug policy. Specifically, the political battle about how to control the spread of AIDS. In this case, the transmission of the AIDS via the interchange of injectable drugs was limited by implementing a

plan for needle control. This had positive side effects by reducing the target of the drug policies, which aimed to impose harm reduction policies and control all the possible sources of infection.

Policy oriented-learning incorporates the role of scientific knowledge and considers how the information provided by experts is able to promote a revision of beliefs in coalitions. Although knowledge is a powerful resource that coalitions use to support their arguments, the impact of expert information is limited because deep core beliefs are extremely difficult to change, even in the face of strong technical references. Nevertheless, information is effective in modifying the secondary aspects of beliefs and in producing minor, as opposed to major, policy changes. For instance, Abrar et al. (2000) examined policies on domestic violence in the UK in 1975 and 1995. Their work supported the ACF argument that, if there is a professional forum providing technical resources to coalitions, policy-oriented learning is expected. In this case, between 1975 and 1995 there was a permanent presence of feminist activists, which created awareness about the need to take action and create policies to stop violence against women.

Negotiated agreement refers to collaboration across coalitions, in which the polarisation of conflicts is reduced, and there is a willingness to reach a consensus. This need for agreement may be stimulated by a situation that the authors called "the devil shift" (Sabatier and Weible 2007; Jenkins-Smith et al. 2015), in which competing coalitions estimate that their opponents are rather powerful and threatening (more than themselves) with the capacity to active the potential institutional and informal veto points against their interests, and therefore, they will actively look to diminish conflict in order to avoid damages (Ingold and Varone 2012). The results of the interaction between groups consist of a process of agreement rather than a sum-zero battle with clear losers and winners. Additionally, this scenario is more likely to occur when coalitions perceive that the costs of maintaining the status quo are too high for them. This is what Sabatier and Weible call "a hurting stalemate' situation, where actors are willing to negotiate and explore alternatives to achieve a plausible solution for all the parties involved. If the alternatives are restricted, the chances of agreement increase because the previously warring coalitions can modify their expectations and get at least some of their policy goals in the public policy outcomes. Sabatier and Weible (2007) proposed a list of conditions for actors who want to pursue this path of negotiation: incentive to negotiate seriously (a hurting stalemate), composition, leadership, consensus decision rule, funding, duration and commitment, empirical issues (a process in which secondary beliefs are modify by the acquisition of new knowledge), building trust, and alternative venues.

After the inclusion of negotiated agreement in the ACF in 2007, only a few studies have explored how and why coalitions collaborate within specific policy subsystems, with the exception of a couple of studies published before 2007, such as Larsen et al. (2006) and Kubler (2001), which illustrate this path. As an illustration, Larsen et al. (2006) investigated the advocacy coalitions present in the discussion of the Danish pharmacy policy from 1996 to 2001. They analysed official documents to identify the coalitions and used qualitative interviews to describe the mechanisms involved in coalition formation and interaction. In looking at the factors that promoted the approval of the pharmacy policy, they found that the original competing coalitions were able to make concessions via compromise (giving up some issues, in order to obtain others). Along with the commitment of coalitions to put the policy forward, Larsen and colleagues (2006) suggest another reason for this compromise among parties: the lack of alternate venues. As the core of the corporatist system is based on the negotiation between the government, interest groups, and associations, there is a limit as to who can get access to the decision making process. If negotiation is the norm for corporatist states, then the challenge for the ACF is to explain those cases in which several venues and competing coalitions try and succeed in influencing the policy process.

3.3.1 Paths of policy change in post-authoritarian countries

Research applying the ACF in former authoritarian regimes, to examine the legacies of the non-democratic governments on new democracies, has increased in recent years. Similarly to the cases examined above, studies from European and Asian countries also show that most of the transformations have responded to external events. Albright (2011), for example, discusses causal mechanisms of change in flood management policies after the natural disasters in 1998 and 2001 in Hungary. She argues that despite these shocks, two other processes were catalysts for policy change: internal democratisation and EU integration. These processes opened new venues for participation. Former minority coalitions were able to take advantage of this particular context to challenge the dominant views of government coalitions. In the same vein, Bukowski (2007) analysed the developments of the Spanish water policy subsystem in both pre- and post-authoritarian periods (1939-2004), and came to conclusions similar to those of Albright (2011). Her findings suggest that the environmental paradigm from the dictatorship (uncontrolled

exploitation of natural resources led by the State) was replaced, twenty years after the return to democracy, by increasing regulation and control of natural resources. This change happened after a combination of various events: the change of political regime in the mid-seventies, a significant period of drought in the centre-south of Spain, the Spanish elections in 1996 and 2004, and the EU integration. However, in this study, the author did not clearly differentiate the paths and the study identifies internal shocks with external events such as causal mechanisms. This is particularly when referring to the periods of drought, which in the latest conceptualisation of the ACF, correspond to an internal episode of the policy subsystem. If we consider this, it is possible to say that two paths of policy change were operating simultaneously in the Spanish case. The combination of internal and external paths is also reflected in the study of Kim (2012) where he examined policy changes in natural resources in the South Korean case. He suggests that in addition to the change of regime in the late eighties, the Asian economic crisis at the end of the 90's and the pollution problems in other parts of the region delayed the implementation of the Saeandgeum Tidelan project.

Until the recent study about the Uruguayan case presented by Freigedo et al. (2015) empirical studies conducted in Latin America have not explored the factors that lead change, mainly focused on the impact of policy legacies on the feasibility of policy change. As such, in studies of Brazilian and Chilean natural resources, legacies from the authoritarian period have caused inertia in the policy subsystems. The study by Carvalho (2001) in Brazil examines the metallurgical development in the Amazonian region. It concludes that due to clientelistic dynamics between the government and the local peasantry formed during the authoritarian regime, this coalition was able to reverse pro-environmental policies, blocking the possibility of environmentalist groups to put the protection of the Amazon on the political agenda. Similarly, Arnold's research (2003) analyses the progress of native forest policy in Chile between 1992 and 2002. He argues that government proposals to regulate the exploitation of native forests were persistently blocked by powerful actors from the forestry industry. These actors were part of the group of entrepreneurs that built companies in a very unregulated context under the military regime, which allowed extensive privatisation of natural resources and social policy areas. Arnold (2003) suggests that the role of the government was rather neutral, as they did not develop their own agenda, but rather tried to mediate between environmentalist and forest industry representatives. Additionally, the author suggests that the lack of environmental civil society organisations (another legacy of the dictatorship) reinforced the control of economic elites. This explains the inertia in this sector after the return to democracy.

Freigedo et al. (2015) shares this idea about the implications of policy legacies on the continuity in the health sector in the study of health policy subsystem in Uruguay. They suggest that the left-wing alliance that took office in 2004, took advantage of the "window of opportunity" opened, to propose and implement a reform in the health sector. Unlike other studies on post authoritarian states, this study brings two new aspects into the discussion. First, the identification of a single dominant coalition that pushed the reform facilitated by compromise achieved by coalitions members forward. Second, the authors expanded their analysis to the implementation stage that prompted the disintegration of the dominant coalition, as they increasingly disagreed on the secondary instruments. In fact, the former coalition members obstructed the implementation process. Freigedo et al. (2015) suggests that the government had "diminishing returns" in terms of their power, which became a weak articulator of the implementation.

This overview of the sub-set of studies applying the ACF analyses policy making in post-authoritarian regimes, showing a variation in the forces that drive policy change and highlight two main gaps, which I will consider in the analysis of the Chilean health reforms, as part of the contributions to this framework. For instance, while the democratisation is confirmed to be an opportunity for transformation, the prevalence of actors or elites from the precious authoritarian could be seen as an informal policy legacy that affects new democratic governments. In Chile, as Arnold (2003) suggests, companies in the forestry sector started in an unregulated environment, strengthening the power of economic groups that wanted uncontrolled exploitation of the forest, obstructing policy change. Thus, the process of inclusion or exclusion of actors as part of democratisation should be analysed in depth.

The last point, similar to the criticism of historical institutionalist accounts, is the predominant focus on exogenous events such as explanatory factors for policy change. This is demonstrated in the case studies from Europe reviewed above, where integration to the European Union has been a source of pressure for implementing reforms in a variety of policy subsystems. While some internal events have been considered in combination with external events in prompting policy change, other paths of policy change from the ACF have been overlooked; in particular, policy oriented learning and negotiated agreement. It should be noted that the lack of research regarding those paths was noticed in the latest review of applications of ACF. This review also suggested that little research has been done into recently democratised countries and in those countries that have not experienced authoritarian regimes (Weible, Sabatier, and McQueen 2009; Jenkins-Smith et al. 2014).

3.4 SUMMARY

This chapter explains the Advocacy Coalition Framework (ACF), assessing its value as an analytical approach to examine the policy process based on the analysis of coalitions interactions, and the mechanisms of policy change in a more integrative manner; to understand the feasibility of transformations in the face of established institutional arrangements and in the absence of external events and shocks.

Restating the contribution of this thesis and before to explain the Chilean context, a brief word is required about what makes this study on the decision-making process in Chile distinctive. As a consequence of the political transactions between political parties during the transition and consolidation of democracy, a large number of studies refer to the Chilean political system in the post-Pinochet regime period as a consensus-driven system (Funk and Navia 2006; Sehnbruch and Siavelis 2014). In this context, analysing the process through the ACF permits us to understand how policy change in the health sector occurred, and presents us with an alternative to the widely accepted institutionalist view that emphasises the inertia of the Chilean political system after the end of the dictatorship (Castiglioni 2006; Ewig and Kay 2011).

By reviewing the various applications of the ACF, I conclude that there is little research in two main areas of the framework: first, the analysis of opportunity structures, particularly in post-authoritarian or non-democratic contexts; and second, in the examinations of paths of policy change beyond the influence of external events. In this way, the explanation of the ACF in this chapter illuminates the main findings of my research, reported in chapters 6, 7, and 8. To contextualise the political process of the health reform, the following chapter presents an overview of the development of the Chilean health system, and analyses the milestones before and after the political regime change.

CHAPTER 4 THE CHILEAN HEALTHCARE SYSTEM

4.1 INTRODUCTION

In the last chapter, I examined policy change theories highlighting the value of the Advocacy Coalition Framework (ACF) such as a theoretical lens to unfold the intervenient factors of the health policy reform in Chile. Taking into consideration that the ACF put particular emphasis on the importance of long-term processes to understand the formation of coalitions and policy change, this chapter provides an overview of the organisation of the health policy subsystem in Chile.

The aim of this chapter is to contextualise the examination of the political process in Chile, analysing the impact of the reforms carried out by Pinochet's authoritarian regime on the subsequent developments in this sector during the first two *Concertación* governments. The purpose of the examination of both periods is to give a better understanding of the underpinnings behind the reform proposed by President Lagos. Considering that the focus of this study is on the policy process rather than an evaluation of the reforms' contents and outcomes, this chapter analyses the milestones of the health sector. Therefore, this shorter chapter is comprised of two main sections that correspond to both pre and post-authoritarian periods.

4.2 A NEOLIBERAL SHIFT ON THE HEALTH SYSTEM

The origins of the health policy subsystem in Chile is understood as a consequence of the achievements of workers' bargaining rights in the first part of the nineteenth century, which led to an expansion of the welfare system in Chile. This is similar to the way the European social protection systems were developed. In 1952, the Chilean health sector was organised following the example of the British NHS implemented four years before, integrating several institutions into one autonomous National Health Service (*Servicio Nacional de Salud,* SNS). This institution was responsible for sectorial plans and guidelines, "acting as a manager, financier and provider of health services for all citizens, but mainly catered for blue-collar workers and indigents, their spouses and children up to the age of 15 (Davila 2005, 16). In coordination with the Ministry of Health, the SNS delegated some responsibilities to regional institutions and was financed by mandatory contributions from employers, employees, and the state. This structure remained until

the latter years of the seventies, when Pinochet's team implemented a substantial reform to reduce the role of the state in favour of a privately managed sector.

One of the facilitators of the implementation of radical reforms in social policies had to do with the authoritarian context. Since Congress was closed down, authorities organised committees within ministries, comprised of military members and technocrats that shared market-oriented views, to develop policy proposals. The technocrats, widely known as the "Chicago Boys", were a group of Chilean economists educated at the University of Chicago and were followers of Friedman's ideas (Gonzalez-Rossetti et al. 2000), that carried out an economic transformation in the eighties, based on the rules defined in the book called "The Brick" (*El Ladrillo*). This volume was a compilation of the various reforms intended to put in place by the militaries and the technocrats, which included the reorganisation a number of areas such as social policies, legal and administrative, among others. The most accurate translation of the Chicago boys' neoliberal ideas was the complete restructuring of the pensions sector, which consisted of the full privatisation of the entities responsible for managing individual savings and the definition of new procedures for worker retirement (Barrientos 2002; Castiglioni 2005)[10].

The Pinochet reform of the health sector was a pivotal plan during his government, in which implemented two main changes: with the first policy, the military government sought to decentralise[11] the previous National Health Service (SNS) into the National System of Health Services (SNSS) (Barrientos 2002; Cereceda and Hoffmeister 2008); creating autonomous health centres responsible for the provision of services at municipal level[12] (Mardones and Azevedo 2006), but the financial matters were administrated by central authorities.

The second change was the privatisation on the providers and insurers side. In 1981, the health system was divided into two institutions: the National Public Health Fund, FONASA (*Fondo*

[10] Ossandon (2008) provide a detailed explanation about the privatised pensions reform in 1981 that led a re-structuring of the health system.

[11] The process of decentralisation could include "a variety of reforms characterised by the transfer of fiscal, administrative, and/or political authority for planning, management, or service delivery from the central Ministry of Health to alternative institutions" (Berman and Bossert 2000,1).

[12] This also happened in the education sector, in which municipalities became the managers of the public primary schools.

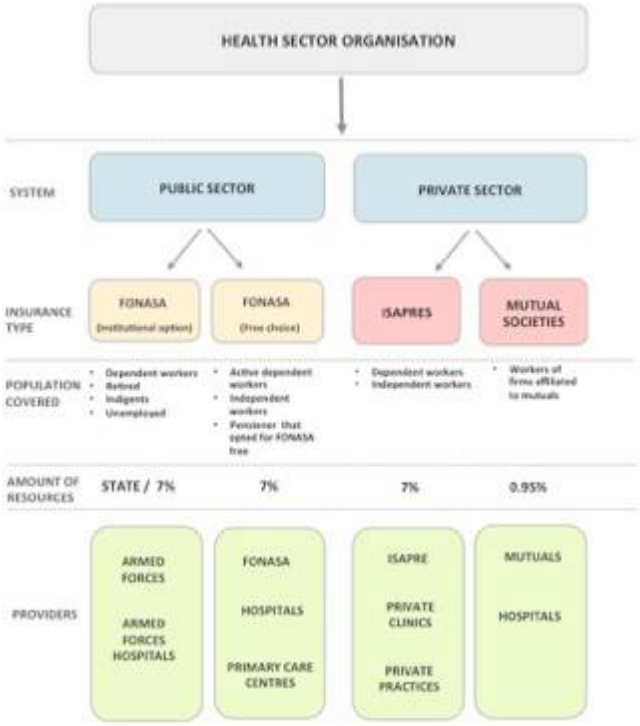
Nacional De Salud) and Private Health Insurance Institutions known as ISAPRES (*Instituciones De Salud Previsional*). According to Unger et al. (2008, 542),

> *"The two systems followed completely different rationales: the public system, a traditional "Bismarckian" social security system (members contribute a proportion of their wages to receive health services according to their need), promoted solidarity via risk-sharing and the internal redistribution of health care resources, while the private system offered health insurance policies corresponding to each individual's contributions."*

FONASA, was created to collect and manage the provision and financing side of the public system, gathering the compulsory contributions of people (mandatory and voluntary that depends on their income and type of job) in addition to the resources from the governmental budget. People enrolled in FONASA are classified in one of four categories: A, for people with no or very low income, while those in the group D have higher income. On the other side, ISAPRES (*Instituciones de Salud Previsional*) manage the accounts for individuals who opted to buy a private insurance. ISAPRES market sells individual health plans, designed according to sex, age, health risk among other specifications established in legal contracts (Cid 2008; Ossandon 2008).

Both public and private institutions are responsible for providing health services. In the public sector, there are two types of institutions: primary centres managed by municipalities, and hospitals with different levels of complexity, administrated by the National Health Service System (SNSS). Private providers offer a wider range of medical facilities, such as private practices, clinics, specialised medical centres, and laboratories. The number of people that opted for ISAPRES progressively increased, reaching around 16% of users in 1990 (Pribble 2013). It should be noted that in 1986, when the contribution for health increased from 4% to 7%, the government offered a subsidy of 2% to incentivise people to transfer from FONASA to ISAPRES (Gonzalez et al. 2000). After both structural reforms, the health system was organised as illustrated in the following table:

Figure 2 Organisation of health system after 1986 to date



Source: Ministry of Health Report (2004); Davila (2005)

As dissention was not allowed and the participation of civil society representatives in the national health council was suppressed, the authoritarian regime could put social policy reforms forward without obstacles. According to Labra (2002), there was a weakening of workers unions, particularly in the health sector, in comparison with the power gained by the private sector. Since its formation in 1948, the *Colegio Medico* played a central role in decision-making as part of the consulting board of the Ministry. Initially, they participated in the discussion, and became an obstacle to bureaucrats' plans since they were seen as being closer to the Allende's, who was a doctor and former Minister of Health. The government took two actions to prevent the conflict with the professional association: first, the discussion of the reform was moved from the Ministry of Health to the Ministry of Labour (as part of the larger plan of reforms). Second, in 1981, Decree Law 3.621 scaled down the power of the *Colegio Medico*, as the government converted all professional associations into corporate associations (*Asociaciones Gremiales*), thus transforming them into groups without compulsory affiliation. The *Colegio Medico* lost two main qualities: the capacity of professional supervision and its participation in policy-making, which in turn, permitted the authoritarian regime to privatise the health sector with less opposition (Castiglioni 2006).

The introduction of the private sector opened the door for the entrance of a number of business groups with interests in the health market. These groups were ideologically close and personally connected with the team of technocrats responsible for the plan's execution. For instance, Gonzalez et al. (2000) illustrates these ties by explaining that Manuel Cruzat, one of the authors of The Brick, was one of the owners of a holding company that had life insurance companies. As a demonstration of the influence of these business groups, in 1984, the ISAPRES created a trade association, the ISAPRES Association[13] (*Asociación of ISAPRES*), to represent their interests in public discussions affecting the industry. The ISAPRES Association is a critical player even in the present day. In this context, the triangulation of interests between right-wing political parties, religious groups, and the economic elite became part of the healthcare sector.[14]

The changes in the health sector during the authoritarian period show an evolution from a highly centralised and publicly managed system to a decentralised structure with a combination of public and private sectors including insurers and providers of health services. The resulting structure enhanced the market mechanisms behind the provision of health services, giving healthcare a status of commodity rather than an entitlement. Even though the Constitution enactment in 1980 guaranteed the right to healthcare, the view within the government was in tandem with the words of the Air Force Colonel and Health Minister Alberto Spoerer of that period, stating that "health care is not given; rather, it must be obtained by the people" (Reichard 1996, 88).

4.3 THE CHILEAN HEALTH POLICY SUBSYSTEM IN THE 1990s

The mixed system created by the reform in 1981, with FONASA and ISAPRES sharing the health market, was preserved in the 1990s. In social policy sectors, the first two transitional governments of Patricio Aylwin (1990-1994) and Eduardo Frei (1994-2000) reduced high levels of

[13] As with any other professional or business groups, these associations are based on voluntary affiliation similar to the *Colegio Medico* after the reform.

[14] For instance, doctors working in private clinics linked with religious groups could not (in theory) offer advice on medical contraception methods, suggesting only natural techniques accepted by the Catholic Church (Dides 2006).

poverty, increased social expenditure and ensured access to health for the most vulnerable segments of the population, rather than carried out structural transformations.

During the first period, in order to compensate the scarce public investment of the preceding period, the Aylwin administration (1990-1994) sought to improve the public subsystem by taking a number of steps to strengthen primary care, improve hospital infrastructure and reinforce prevention and promotion as public policies. Two Ministers led this process, Jorge Jimenez de la Jara and Julio Montt, both from the Christian Democratic Party. One of the most important initiatives of the Aylwin presidency was to strengthen the supervisory capacity of the state over the ISAPRES, by creating a *Superintendencia* as the main regulatory body for private health insurance companies. Specifically, this institution developed specific regulations (from general laws) and produced statistics and rankings about the function of the market and the firms involved (Ossandon 2008).

The second phase took place during the government of Eduardo Frei (1994-2000), which sought to modernise the public sub-system by strengthening the regulatory role of the Ministry. Ministers Carlos Massad and Alex Figueroa, also from the Christian Democratic Party were responsible for these initiatives, for instance, the approval of the “FONASA" law that strengthened the duties of the public sector, and some changes in the "Medical Act" to regulate the contracts of municipal employees, and their services. Although the initiatives of previous governments helped to reduce the deficiencies in healthcare, various factors were still disturbing the health system. Data from the health sector shows, such as the distribution of affiliates from 1990 to 2000 in the next table, part of the problem that this reform intended to address.

Table 5 Distribution of affiliates to FONASA and ISAPRES (%)

Year	FONASA (%)	ISAPRES (%)	OTHERS (%)
1990	73.1	15.9	11.0
1991	69.5	18.9	11.5
1992	63.7	21.8	14.5
1993	60.9	24.5	14.7
1994	60.6	25.7	13.7
1995	59.6	26.0	14.4
1996	59.0	25.9	15.0
1997	58.8	26.1	15.2

1998	60.5	24.4	15.1
1999	61.5	21.7	16.8
2000	65.6	20.0	14.4

Source: FONASA

By 2000, FONASA covered around 66% of the population, whereas the private sector covered approximately 20% of the population. Although it could be argued that the problems of ISAPRES be restricted to the population who subscribed to private insurance plans, the effects cream skimming had an impact on the entire system. One the one hand, there was discrimination in the selection of people according to their risk in the access to health care, creating a segmented and inefficient market for the public sectors. In fact, between 1990 and 1998, ISAPRES received around 40,3% of the health expenditure from the public budget and covered less than 18% of the population (Cid 2008). The unbalanced distribution of patients is another problematic issue emanated from the dual systems, where the distribution by income quintile shows that the highest income groups were concentrated in ISAPRES (Quintil V) and the poorest in FONASA (Quintil I):

Table 6 Distribution of health insurance system by population quintile income, 2000.

Quintile	FONASA	ISAPRES	OTHER
I	87,5	3,1	9,4
II	80,1	7,8	12,1
III	61,0	7,6	25,4
IV	53,4	29,5	17,1
V	29,6	54,2	16,2

Source: Cid 2008.

Besides the concentration of wealthy people in ISAPRES, it also had a higher percentage of the younger and healthier segments of the population, as private insurance companies are reluctant to accept individuals over the age of 60 and "women on a reproductive age" (Ferrer 2004). As there was no regulatory framework, ISAPRES were able to adjust their premiums by age and gender group, according to the potential individuals' risk, in what it is called cream-skimming (Bitrán et al. 2008). They could reject them based on pre-existing medical conditions, or significantly increasing the price of insurance plans. By 2000, there were approximately fifteen

ISAPRES, which offered around 16,000 different health plans with various levels of coverage for specialists appointments, medical treatments, operations, depending on the cost of the plan (Bitrán et al. 2008; Ossandon 2008). These companies sold special plans for women between 20 and 38 years old, colloquially referred to as "uterus health plan" and "non-uterus health plan" (Planes con o sin utero), that is, if a woman was planning to get pregnant, the price of the plan was higher, if not, the plan was cheaper. According to the private insurers, this disparity in prices is related with costs associated with post-natal sick leaves (Gideon 2007). Additionally, ISAPRES restricted the mobility of patients as information was shared by the entire private insurance system (without authorisation of patients). If a person decided to leave an ISAPRE, they could get a rejection from other companies because of a pre-existent condition or risk associated with their clinical history. The lack of regulation was crucial in permitting these discriminatory actions (Drago 2006; Cid 2008; Ossandon 2008; Pribble 2013).

Conversely, FONASA was composed of the elderly, those who had chronic diseases, people with lower incomes, and the homeless. In the public system, the primary centres and hospitals provided services where poor infrastructure, waiting lists, and lack of personnel and specialists, made services lag behind those provided by private practices and clinics. Another difficulty was related to doctors' schedules. In public sector, salaries were less competitive than in the private sector and it was very common for doctors to concentrate their mornings in public institutions while working in private clinics where they could receive higher wages in the afternoon. The consequence of this dual practice was that hospitals did not have the necessary personnel in the afternoon. They were unable to provide appointments or perform surgery for people covered by FONASA, which reinforced the inefficiency of public institutions, causing long waiting lists and dissatisfaction among users (Montt 2005; Sanchez and Labbe 2005).

Ten years after the return to democracy, President Lagos sought to address the imbalances between the public and the private system, as well as emphasising citizens' rights as the foci of the reform to change the individualist approach of the existing model. Being the first non-Christian Democrat president after the transition gave him the leeway he needed to present a more progressive social agenda. The two most important areas of the reform proposal were: first, the introduction of a set of laws designed to regulate private sector activities. And, second, making the State a compulsory provider and legal guarantor of a new program to ensure universal access and financial support for a list of conditions prioritised according to the recurrence and costs by the AUGE Plan (*Plan AUGE),* which is a system of Universal Access with Explicit Guarantees. Although

this reform was widely known as the AUGE reform after the most recent programme, the original Lagos bill was comprised of five specific laws, which were the following:

Table 7 Lagos health reform proposal

LAW TITLE AND NUMBER	DESCRIPTION	SUBMITTED TO THE CONGRESS/ APPROVED
Law No.19.888: Funding	Guarantees financial resources for the reform, including a 1% increase in the value added tax (VAT).	09 June 2003/ 14 July 2003
Law No.19.966: General Guarantees in Health (Plan AUGE).	Creates a system of explicit guarantees in access, opportunity, quality, and financial protection for a list of priority pathologies. The public and private sector were obliged to provide these benefits without conditions.	22 May 2002/ 25 August 2004
Law No.19.859: Private Health Insurance Solvency	Ensures the system's stability and protects affiliates.	11 June 2003/ 28 August 2003
Law No. 20.015: Private Health Insurance	Improves transparency and control through the establishment of a regulatory agency called "*Superintendencia of* ISAPRES."	02 July 2002/ 17 May 2005
Law No. 19.937: Health Authority	Separates the roles of health care and health regulation, and creates a system of accreditation of public and private providers.	02 July 2002/ 24 February 2004

Sources: Ministry of Health Report (2004); Congressional Hearings (several years)

The idea of the reform was announced during the Lagos's presidential campaign, where he expressed his will to make substantive changes to the health sector, and it was confirmed after he took office, in his first annual speech in the Congress in May of 2000, initiating the policy process of the health reform.

4.4 SUMMARY

This chapter aimed to present the main features and trajectories in the Chilean health system, providing the contextual factors to understand the Lagos' health reform process. It argued that Pinochet's dictatorship left a myriad of legacies within the health sector that explain the subsequent developments within this policy subsystem in the new democratic period. Specifically, the introduction of the private sector as an insurer and provider of health care following the neoliberal principles promoted by the military authorities and set up by a group of technocrats in 1981. With this background and after the return to democracy in 1900, the subsequent Chilean governments have mainly maintained the free-market model implemented under Pinochet´s regime. The first attempt to introduce a substantial reform, in this sector was prompted by President Ricardo Lagos in 2000, aiming to correct the adverse effects of the neoliberal reforms. Before this initiative became a law five years after the announcement, there was a long period of design and formulation, which is the political process analysed in depth in chapters 6, 7, and 8 of this thesis. The following chapter presents the research design of this study, explaining decisions and procedures in the collection and analysis of data.

CHAPTER 5 RESEARCH DESIGN

5.1 INTRODUCTION

The previous chapter provided an account of the health system organisation in Chile, to contextualise the political process of the reform proposed in 2000, from which it is possible to get a better understanding of this thesis' findings explored in the followings chapters.

The current chapter presents the study design and methodological decisions that I made to analyse the Lagos health reform through the lens of the ACF, which follows the qualitative tradition of previous advocacy coalition studies. The aim of this chapter is therefore, to provide clarity regarding the research process I engaged in, explaining the choice of a case study design, as well as the techniques employed during the process of data collection and analysis.

This chapter begins by explaining the rationale behind the research design and methodology used. The second section provides a description of the process of data collection from two main sources: documentary analysis and elite interviews. This is followed by explaining the strategies and steps involved in the process of data analysis. The last section offers a reflexive account of my experience conducting this doctoral fieldwork.

5.2 THE RESEARCH DESIGN: A CASE STUDY APPROACH

In terms of research design, either deductive or inductive reasoning can be used to gather information about the object of study, which might be employed iteratively in the course of the investigative process. Given the nature of my research question and the theoretical framework used, I employed mainly a deductive approach as the examination of the Chilean case was ACF-driven, in which the research followed a theory that guides the data collection and analysis (Harrinkari et al 2016). Considering the growing applications of the ACF, methodological challenges have increased simultaneously in case studies as well as comparative empirical works, as researchers are required to clarify the steps of research and analysis more precisely, in order to strengthen the use of the framework in wider contexts, topics and policy subsystems. In particular, early ACF investigations were distinguished in terms of research techniques in a Sabatier and Jenkins-Smith´s book (1993) and later works were updated in two thorough reviews made by

Weible and colleagues (2009; 2011) pointing out the state of the methods' designs and different focuses within the advocacy coalition framework. As these compilations show both methodological strands, qualitative and quantitative (and mixed methods) have been followed by scholars to analyse the policy-making processes depending on the theoretical emphasis given in each study. For instance, Weible et al. (2011) point out that ACF literature has tackled three main lines of inquiry such as structure coalitions, political learning, and policy change. Guided by the ACF model, the choice of the research design and methodology choices varies from those studies which are hypothesis-testing oriented, where the quantitative work puts emphasis on the numbers, amounts, or frequencies of the variables examined, helping researchers to confirm if a case(s) is congruent with theoretical propositions (Denzin and Lincoln 2011). It is worth noting that within the ACF, that although in this thesis there is no use of statistical hypotheses, the ACF model includes a series of 9 statements that have been tested by scholarly research applying quantitative techniques of analysis to explain beliefs change and coordination[15]. In the range of these techniques, recent studies have employed for instance, Social Network Analysis (SNA) to map actors within coalitions, given the similarities with the concept of policy communities and networks (Adam and Kriesi (2007), with the aim to unpack the connections and ties among actors. Another technique of research used to test hypothesis has been content analysis of political statements, or congressional hearings when data is available that include the conversion of those statements in frequencies and then analysed statically.

When it comes to looking for in-depth explanations about advocacy coalitions, qualitative methods are the choice of research. In this case, the process of data collection also offers various options, such as in qualitative case studies, where it can actually employ different techniques, which include interviews, focus groups, surveys and historical documents, which are chosen by their validity for the case in question (Buttolph, Johnson and Reynolds 2008). As a non-experimental method, qualitative research seeks to investigate the significance and qualities of social phenomena thoroughly, focusing the analysis on a specific decision, place, or problem (King et al. 1994). Seawright and Gerring (2008, 105-6) observe, one of the primary virtues of the case study method is the depth of analysis that it offers. Here, depth refers "to detail, richness,

[15] The list of the hypothesis and its discussion can be found in the article of Jenkins-Smith et al. 2015, pages 195-204.

completeness, [and] wholeness." Given the lack of capacity to develop statistical inferences or identification, or law-like regularities, such depth may present both strength and weakness in qualitative case studies. However, scholars defend its utility for producing significant insights from one single study that could shed light on the phenomenon, produce theoretical generalisations, or open new areas for further research on a large-scale project. With the purpose of illuminating the decisions around the political process of the health reform, I have opted for a qualitative research design that allows me to conduct research emphasising depth rather than breadth (Ulin et al. 2005). These mechanisms allow the research to extend the explanatory capacity from an individual case study to a larger class of units (Gomm et al. 2000; Gerring 2004; Flyvbjerg 2006; Swanborn 2010). Suggestions to overcome limitations of qualitative case studies have been focused on a detailed process of research, stressing that such research should include: a clear theoretical framework and a solid methodological design that supports the reliability of the findings and avoids ad-hoc conclusions (Yin 2002; Flyvbjerg 2006). For example, Yin (2002) indicates that in the case of data collection, rigorous research includes the following steps: attentive observation of the context around the issue under analysis that supports the credibility of study findings; a clear definition of measurement instruments; a careful and exhaustive review of multiple sources, coherent with the line of inquiry. Regarding the generalisation of this case study, I expect that the conclusions that emerge from this thesis may shed light for further research in other social policy areas. Using the same methodology, in different policy subsystems, for instance, education or pensions, one could find the same types of actors, coalitions in this case, that could lead a different explanation of similar problems. This study therefore, expands the qualitative strand of the ACF.

Previous studies with qualitative techniques for data collection has been used by Winkel and Sotirov (2011) Harrinkari et al. (2016) and Menahem and Gilad (2016) where the process of data interpretation is embedded in the process of coding and interpreting interviews and written sources, with the main purpose of identification of advocacy coalitions and their beliefs. Winkel and Sotirov (2011) for example, interrogated policy stakeholders in the forest sector in Bulgaria, and data collected was code guided by the ACF. Findings showed that the interaction of advocacy coalitions in national forest policy were influenced by external events, were previously stated commanded policies, and were replaced by the dissemination of market oriented management after 1990. Mixed methods have also been used for the ACF examination. With a focus on policy change, the work of Leifield (2013) combines both a qualitative content analysis and a social

network analysis, revealing the existence of a transition from one coalition to another dominant coalition that was able to bring about a pension reform in Germany. The research techniques helped to operationalise the content of actors 'discourses (from newspapers archives) and transformed into binary data and then to a graphical representation of networks within the previous and subsequent dominant coalition.

Another way to explore actors´ opinions is presented by Fisher (2014) who took a step forward in the examination of coalition structure in Switzerland, integrating Qualitative Comparative Analysis (QCA) software to identify causal relationships between advocates and policy change processes, measuring the degree of consensus. Based on the data from expert surveys in various policy sectors, the author concludes that dominant coalitions do not necessarily lead to major policy as it is requires a certain degree of collaboration, low intensity conflicts among coalitions, and specific opportunity structures. Further research might depart from these results and expand the explanatory power via the replication of surveys in other cases. In my study for instance, a survey would not have been a suitable technique of obtaining information, as this type of instrument is more adequate for gathering responses to standardise questions and produce aggregated results from a large selected number of participants. Moreover, surveys of different types, e.g. descriptive or longitudinal, aim to establish trends and a cause-effect relationship between variables rather than analyse the meanings of the phenomena. Therefore, they might limit the capacity of the researcher to fully capture individual perceptions and knowledge from a respondents' narrative. For this reason, my choice was to conduct elite interviews and document analysis, as both techniques provided me with a great deal of flexibility in my search for a comprehensive account of the policy process. Thus, in developing the interviews schedule and the collection of various documents, I was informed by both previous ACF studies and literature about health reform processes in Chile and elsewhere, to get a sense about topics and samples that other researchers have considered beforehand in the analysis of this sector. This characteristic helped me to define my questions and to re-evaluate the direction of my research while I was doing fieldwork. A semi-structure interview is one of the two methods of choice to identify coalitions as well as the narratives of policy process from the actors itself. The second method, documentary analysis, consists of the exhaustive examination of a wide array of documents, such as official reports from governmental institutions, interest group publications, newspapers, congressional hearings, to name a few. Data from both sources are coded and analysed based on thematic analysis, as it is explained in the following sections.

5.3 DATA COLLECTION METHODS

As the central purpose of my research is to gain a better understanding of the process by which the health reform was designed, discussed, and passed within the Chilean political system, documentary analysis and interviews provided a narrative about the history and configuration of events. From this, I was able to draw general conclusions about the health reform process. Data collection was based on two main sources: the examination of documentary sources and semi-structure interviews with the Chilean politicians and elites connected to the reform being studied. However, separately, these sources did not provide an accurate representation of the policy process, and none of them were treated at face value for several reasons, for instance, due to the biases of public media or the self-perception of power from respondents. It is worth noting that, to judge the validity of my interpretations in the appraisal and evaluation of written records, I consider how and in which context these documents were produced (MacDonald 2001, 31). Furthermore, I was aware about the necessity of integrating all forms of data that could provide me with a more thorough picture. For instance, to get a better grasp of the events I read about, I needed, in order to elaborate an in-depth narrative, to gain a greater understanding of the actors' views. In the next section, I examine how I utilised both sources and the challenges I faced in their collection.

5.3.1 Document analysis

The starting point of my research consisted of examining the documentary data to identify the main actors, political events, and processes during the discussion of the health reform. Documentary sources were collected for the period 2000 to 2006, with two main functions: first, it provided a detailed landscape of the Chilean political system and health sector as portrayed in the public domain; and second, it helped to identify the people that would be interviewed during fieldwork. The focus of the documentary appraisal was on those documents with information about the actors and their opinions, rather than on the technical aspects of the reform, such as indicators or economic calculations from the reform proposal. Although I tried to recover as much of the information available as I could, some data could be missed from reading the public records, for instance, informal institutions or venues. As such, the triangulation (which consists of a process to confirm a proposition through the examination of various independent source/methods) of different

data sources was a key step to reducing potential bias in the analysis of responses (Bowling 2002; Yin 2002). In order to avoid the problematic partiality related with a single method of data collection, my data was gathered via different techniques, interviews, and document analysis (Rubin and Rubin 2011). This provided the multiple angles necessary to question the policy process and create a convergence of findings. This is why, in addition to the interviewees' narratives, it was important to compare different sources. The documents I reviewed are elaborated on in the section below.

5.3.1.1 Institutional materials and publications

Reports and minutes created by non-governmental actors, for instance, think tanks and private sector companies or associations were reviewed. Think tanks from both sides, close to both the centre-left and right wing parties, which produce regular reports on different policy areas, including health, were chosen. From the centre-left, the *Concertación* publications from *Centro de Estudios del Desarrollo (CED), Fundacion Chile 21 and Expansiva* were considered. From the think tanks close to the right-wing *Alianza*, papers and reports from *Libertad y Desarrollo (LyD*), *Instituto Libertad (IL)* and *Centro de Estudios Publicos* (CEP) were included in my review. Other publications prepared from the specialist research of the Unit of Legislative Process Support from the Library of Congress were also included. All these documents are listed in the references section and some are cited in the chapters of this thesis.

5.3.1.2 Transcripts of Congressional Hearings

I collected a set of documents from the Library of Congress called the History of Law (*Historia de la Ley*), which are similar to the British Hansard, which includes a compilation of written records from congressional hearings. These large sets of documents (around one thousands pages each) contain the presidential message in which the bill is explained and delivered to Congress, as well as a complete transcription of the debates that took place within Congress. I looked at these documents for each bill of the health reform package that were presented to Congress, from 2002 to 2005: History of Law No.19.937 (Authority Law), History of Law No.19.966 (Plan AUGE), History of Law No.19.888 (Health Financing Law), History of Law No.20.015 ('large' ISAPRES

Law) and History of Law No.19.859 ('brief' ISAPRES Law). These transcripts reflect the legislative debates in both chambers (Deputies and Senate), including sessions with all its members (*discusión en sala*) or/and debates within specific sectorial committees (*discusión particular*) that are sometimes open to people invited by congressmen to discuss a particular issue of the bill. Furthermore, looking at these documents allowed me to gain information about who was invited and what they proposed, vis-à-vis legislators' views.

5.3.1.3 National newspapers

I searched in digital archives of articles in the Chilean mainstream press from March 2000 to December 2005,[16] using the following keywords: *salud* (health), *sector salud* (health sector), *reforma a la salud* (health reform), *Plan AUGE* (AUGE Plan), in the most widely read national newspapers: *El Mercurio, La Tercera, La Segunda, La Nacion. El Mercurio y La Segunda* (a political and business focused evening paper) are publications from the company El Mercurio SAP, while *La Tercera* belongs to the COPESA Company. Both conglomerates are owned by two of the richest families in Chile, Edwards Eastman and Saieh respectively. Given their market concentration and influential relations with the Chilean elites –which is related with the informal networks within the country explained also in Chapter 2- (Gronemeyer and Porath 2015), these two conglomerates are normally referred to as a powerful duopoly. *La Nación* was a daily, government-subsidised, newspaper and therefore closer to official authorities, but its print version was cancelled during the Sebastian Piñera Administration in 2012. I also consulted press notes from publications with lower circulation but widely read by the Chilean elite such as *Diario Siete+*,[17] *Diario Estrategia* and *Revista Que Pasa*. The circulation and readership for these newspapers is summarised in the following table.

[16] As this research does not include the implementation phase, I narrowed my search until the year the Congress enacted the last law of the health reform.
[17] Diario Siete + was a weekly newspaper published from March of 2002 to September 2004.

Table 8 Chilean newspapers figures

Newspaper	Format	Circulation	Readership
El Mercurio	Broadsheet	166.698 *Double on Sundays' edition	372.475
La Segunda	Weekly afternoon paper-compact format	32.000	74.687
La Tercera	Broadsheet	137.179	367.017
La Nacion	Daily-compact format *Until 2010	10.000	31.520

Source: Data from Benavides et al. (2009) for the first semester of 2007[18].

Being aware that there is a potential for bias (Bowling 2002), in particular, regarding the mostly right-wing political oriented Chilean press[19], I triangulated the information from these sources with legislative documents and the opinions collected in the interviews. Information found in the press was used as a reference to understand the context and objective facts during the process, as well as the provision of names for my interviews. A limitation in reviewing these secondary sources was the inaccessibility of governmental minutes and reports from the activities of the Minister and the executive committee. When I asked the library of the Ministry of Health regarding information on this process, they said they did not have information and referred me to Doctor Carlos Montoya, who has published a couple books about the Chilean health system. When I got in contact with him, he also explained that he was also not able to find this information, so he had to rely on the information found in the media. Furthermore, at the time of my fieldwork, the first

[18] The National Agency Press (ANP) not longer provides these data, so I looked at other sources that had collected appropriate data. Although the year reported exceed the period of the reform under examination, figures presented here are consistent over time, after checking other sources, for instance: https://www.opensocietyfoundations.org/sites/default/files/mapping-digital-media-chile-20121122.pdf

[19] Regarding the bias to the right, Navia and Osorio (2015) remark that the main newspapers in Chile, *El Mercurio* (and its evening paper, *La Segunda*) and *La Tercera*, represents the interests of the right. This has its origins in the newspapers opposition to the governments of Eduardo Frei (1964-1970) and Salvador Allende (1970-1973) and a propagandistic support of the Pinochet dictatorship (1973-1989). It is also worth noting that according to the CIA reports disclosed on 2003, *El Mercurio* and its owner, Agustin Edwards Eastman, received funds from the US government to pursue activities in order to destabilise the Allende Government.

right wing government since 1990 was elected into office, meaning that people who had managed that information from previous periods were probably no longer there. This is one of the reasons why the interviews, which I will explain in the following section, were a useful source of data that allowed me to obtain the narratives of former authorities.

5.3.2 Fieldwork in Chile: interviewing political elites

I conducted fieldwork in Santiago, Chile after obtaining approval from King's College Research Ethics Committee (REP(EM)/12/13-3) from November 2012 to January 2013, and from October 2013 to January 2014. The main purpose was to conduct interviews with political, technocratic, and economic elites involved in the Chilean health sector. I included those individuals who had formal positions of power, or were appointed in specific roles within governmental departments, political parties or interests groups. These held roles such as ministers, congressional representatives, and leaders of trade unions, among others. I also considered those individuals who were not in publically visible positions, such as advisors or technical professionals who, given their credentials and expertise, had privileged access to decision-making centres and regularly participated in the policy process. To define my sample, I followed a purposive sampling criterion, based on my previous knowledge about the policy process in Chile and information from other studies that have previously examined the health sector, in which I sought to interview a group of individuals that were part of the policy formulation process. These persons could share their valuable knowledge with me regarding the political context and views around the political process in which they were engaged.

This selection of participants was supplemented by snowball sampling. During fieldwork, at the end of each interview, I asked the respondent if she or he could suggest other people for me include in my list of interviewees. This was a useful procedure as various participants offered to call, during the interviews, other persons to arrange a meeting. I also asked for other names which, after few meetings, resulted in the same names being repeated, which mainly confirmed the informants I needed to recruit. As qualitative research is based on the assumption that reality is not objective, and social phenomena are always complex; the understanding of the health reform process has to include an analysis of the perceptions, motivations and opinions that influence interactions and social constructions between individuals. To capture these individuals' meanings,

the data collection method in this study was a semi-structured one-on-one interview. This type of interview was the preferred option for exploring political elites' perceptions, as it did not restrict the richness of responses obtained, unlike a rigid questionnaire.

I completed 26 elites interviews[20] out of 37 people contacted in both trips. From this number, just one person, a doctor specialising in public health, actively refused my request for an interview. He gave me a personal opinion regarding the process, saying that the issue was still very sensitive and he was not responsible because other people did not do what was appropriate. The remaining ten people either did not reply to my contact, excused themselves for medical reasons, or due to a lack of time. Of course, they were aware that they could have used those justifications to hide the fact that they were not inclined to give me an interview.

During these interviews, an interview guide, with a list of questions and topics to be covered, was used and focused on the opinions and experiences of interviewees during the reform process. Informed by health policy literature that has previously studied the political process of reforms (Kaufman and Nelson 2004; Castiglioni 2005; Wong 2006; Haggard and Kaufman 2008, among others), the interview schedule was based on four categories of open-ended questions permitting a 'responsive' interview technique (Rubin and Rubin 2011). The categories used in the topic guide were: a) Knowledge and position about the reform b) Macro-institutional context, c) Relevant actors; d) Decision-making process. Questions were added depending on the interviewee to explore more in-depth aspects that emerged during the conversation. A preliminary interview schedule[21] was discussed with my supervisors twice, then, to test questions, timing, and coherence of the schedule, the instrument was piloted with a colleague in Chile. After this procedure, some questions were rephrased, and the general order of the schedule was refined to ensure that the conversation could flow properly.

An Information Sheet and Consent Form (Appendix B and C) was sent to participants by email when meetings were arranged, and at the beginning of the meeting participants were asked to read the information letter and sign the consent form. All the interviews were conducted in Spanish (my

[20] A list of interviewees is included in the Appendix D.
[21] The schedule is included in the Appendix E.

mother tongue), and they generally lasted between 45-90 minutes.[22] They were all audio-recorded and transcribed by myself. While 23 of the interviews conducted in Chile where face-to-face, after returning in London, I managed to carry out three interviews by phone/Skype. With the exception of the lack of personal interaction, I did not encounter any particular problems using this type of communication.

In the analysis process, interviews were not taken at "face value". I am aware that politicians and elite members are individuals who are aware of their status, and for whom, their public image is very important. They are also experts in media interviews and self-presentation and are aware of how they can exercise their powers. All these factors may affect what they say even in reference to an event in the past (Arksey and Knight 1999; Odendahl and Shaw 2002). My responsibility as a researcher was to elicit their communication, to interpret their responses in context, to unpack what they were (not) saying, and to contrast and compare the information provided by them.

The triangulation of data across different sources was employed, comparing the various interviewees' stories with the accounts from documentary analysis and media information for a more comprehensive picture of the process. For instance, one of the former Ministers of Health, Osvaldo Artaza, explained to me that one of the reasons he was removed from his position was his conflictive relationship with the president of his political party (Christian Democrat). This was at odds with what I read in one of the books about the reform (Olavarria 2011) which says that the higher authorities in his party supported Artaza and so I realised that this dissimilar account of events needed to be tackled with caution. Other researchers have faced similar challenges, for instance, Duke (2002) mentioned that her initial work on policy networks was on prison drug policy, followed by a strategy of methodological triangulation. Her first step was analysing documentary records, as many actors were involved in the production and consumption of a number of written sources. This information was later ratified in semi-structure interviews. According to the author, as was the case for my own research, interviews were the only way to

[22] Two particular interviews lasted 20 minutes; see Fieldwork Evaluation section in this chapter.

generate rich and detailed data on their perceptions and experiences, but both processes of data collection are interconnected in providing an in-depth knowledge of the case.

In reflecting my 'positionality' in doing this fieldwork, I can see that there were advantages to being a relative 'insider'. My insider status facilitated access to my sample, as I spoke the language, knew the cultural environment, and had an existing network of contacts. Although, I am neither part of the economic or political elite, or a political party militant, my educational background (I studied Political Science at Universidad Catolica de Chile, which is one of the top —semi-public— Chilean universities) and professional credentials opened doors when approaching potential interviewees. As I have previously worked in two of the most important universities in Santiago, where I met and collaborated with well-known professors, politicians and policy-makers; as in Chile it is a common practice for former politicians to occupy academic positions when they retire and academics often leave their jobs at universities to work in the public sector. All of these contacts facilitated my access to key informants.

The literature on elite interviews suggests several ways for recruiting respondents: network contacts, gatekeepers, and events attendance (Arksey and Knight 1999; Odendahl and Shaw 2002). In my case, I followed all the routes mentioned. In general, I relied a lot on my personal contacts, as I knew they might know people in the area and who were willing to help me. This was the case with a friend's mother, who knew one senior executive of an ISAPRE because they were both members of the Catholic congregation "Legion of Christ". To book an appointment with him, I wrote an email to him, pointing out that I was a friend of my friend. After this email, it was a very straightforward exchange and he became my first interviewee in December 2012.

My interview with President Lagos was through a previous colleague. She was an advisor to the President during his administration, and after that, she was still working with him on a temporary basis. She introduced me to Lagos' personal assistant via email, asking her to put me in his calendar for an interview about the health reform. After a couple of weeks, the assistant wrote back to me, saying that the president would be able to meet me for half an hour. She also invited me to stay with him afterwards in a meeting with a team of students from Harvard that were there for a seminar about public health in Chile. This was the last interview during my first trip to Chile, which was rather convenient as I was far more prepared at the end than at the beginning of my fieldwork. The gatekeeper, the President's personal assistant, was key, because she was the one who mentioned my research to the President and asked him to give me space in his schedule. All

of this worked well because my colleague and this personal assistant have been working together for several years, but also because my colleague trusted my skills as researcher and my personal integrity.

I also attended some events to gain access to interviewees. One of them took place in London, where I had a second chance to arrange an interview with a former Deputy and Senator (who previously cancelled an appointment booked in Santiago) while he was on a personal trip (his wife was studying English in London) in an event organised by Canning House. I approached him to ask for an interview and he agreed to meet me at the Chilean Embassy that afternoon. In other cases, there were people who were not in my networks and I just made a cold contact with them by email, explaining my research topic and asking for an interview. This approach also worked on a number of occasions, and people without having much information about me, gave me an appointment. Recruitment of informants ceased when I reached a saturation point, meaning that additional interviews were not providing new information.

According to Gubrium and Holstein (2002), one of the challenges in doing interviews is the dynamic between the informants and the researcher. One of the factors that can affect this dynamic is gender and also class position. In my case, I would say that, generally, being a female researcher did not adversely affect my position as an interviewer, but it would be fair to say that in the opposite way, they did not felt threaten or uncomfortable to be interviewing by a woman and they therefore spoke freely. Even when some respondents tried to take control of the questions, I would say they did not adopt a condescending position because I was a woman necessarily; but this more neutral and collaborative attitude was explained more based on my appearance and the fact that I have Caucasian facial features which is identified as someone from the upper class “to be one of them”. I might say that a favourable tone of the conversation would be also similar with a young male researcher with similar physical attributes than me; but it would be certainly different if the one conducting the interview was a woman from an ethnic minority from Latin America with darker skin or with a recognisable indigenous name, that could even not get access to the elite because “it did not seem part of them”.

I do recognise there is gender issue in terms of representation, in the sense that all the informants, with the exception of two, were male. The two females I did interview occupied advisory positions but did not have an official role. Although three more females were contacted (but did not respond), this gender balance is indicative of the lack of women’s participation in the

decision-making sphere in Chile at the time of the reforms. For instance, calculus from the Electoral Service data show, the average female representation in the Congress from 1990 to 2010 was 11% in the Lower Chamber, while in the Upper Chamber it was 6,2%[23]. Nonetheless, it is worth noting that during the second fieldwork phase, two prominent politicians there were involved in the Lagos' health reforms. Both Michelle Bachelet, former Minister of Health and elected president in 2006, and Evelyn Matthei, a Senator from the UDI party were running in the presidential election of 2013, that could be seen as a slight signal of improvement in this unbalanced situation, but I would say that the gender equality gap is still an overlooked issue in the Chilean society.

In general, I would say I felt comfortable during the interviews and people were very respectful when they learnt I was studying in London, sponsored by a prestigious scholarship from the Chilean government (various people asked me about my funding for studies in the UK). I think these credentials helped me to establish a rapport with informants and to have a cordial interview dynamic. With the exception of two cases, both happened to be deputies, people took time to answer my questions with good disposition. Furthermore, one of my interviewees, a former Minister of Health, called me three times to arrange a second meeting. At the same time, he told me that he was looking for someone to write a book about his experience during the reform, but did not ask me anything after the meetings. Overall, I think most of the respondents were pleased by the fact that, after almost ten years, someone was interested in what they did during the policy process.

Scholars such as Arksey and Knight (1999), Duke (2002), Gubrium and Holstein (2002) point out that anonymity is an issue and challenge facing researchers conducting elites interviews. Given the position of authority of the participants, their opinions and comments could be used by others, something the participants are aware of, and therefore, might be reluctant to be cited or named. However, in my research, all the respondents accepted the terms described in the consent forms regarding interview recording and the identification of participants by their names. A couple

[23] Data available at http://servel.cl, retrieved September 20 2015.

of informants asked me not to transcribe some phrases or asked to talk off the record during the conversation and this information was not transcribed. It is worth noting that in most cases, these comments did not add substantial information. When I noted that something could be important, I tried to ask them in a different manner when I was allowed to record again. In general, anonymity did not determine the content of the conversation. People seemed to talk very freely during the interviews, and doing the interviews in my mother tongue was certainly an advantage for having a fluid conversation. It is worth noting that most of the participants who were part of the Lagos Administration were not in governmental positions at the time of the fieldwork. This was due to the changes in the presidency that moved from a pact of centre-left political parties to a right-wing alliance. Some of the former politicians were in academia, some others worked independently, and others were occupying seats in Congress. Instead, during the fieldwork, people close to the right wing were in the government and I could perceive that some of them, i.e. a person working in the Ministry of Health, had a more critical view of the ISAPRES than I have would expected.

In relation with the timing of my fieldwork, gaining access to people in the second round of interviews was more challenging because there was a presidential and parliamentary election in December of 2013. Potential interviewees were involved in political campaigns; including the two candidates running for the presidency, Michelle Bachelet and Evelyn Matthei. Both were key actors in the reform under study: one as the first minister of health, and the other one as a senator. After several attempts, neither of them was accessible. While contacting Bachelet was impossible (although I knew people that were working with her campaign), Matthei agreed to give me an interview by Skype after her holidays.[24] However, when I emailed her for a follow-up, she never replied. I was informed by the press that, after the elections, she retired from the public scene and became a maths professor in a semi-public school for poor children.

[24] Evelyn Matthei lost the presidential campaign against Michelle Bachelet in the second round of voting on December 15, 2013.

5.4 THEMATIC DATA ANALYSIS

In order "to identify, to analyse and to report patterns or themes within the data", this case study adopted a thematic analysis as a qualitative analytical method (Braun and Clarke 2006: 79). The researcher embraces an exhaustive data review and interpretation in this process. This case adopted a deductive approach and used personal accounts and documentation to gain a better understanding of the phenomenon of interest. After the process of data collection –informed by literature on ACF and health policy– the construction of meaning and interpretation was a crucial part of developing conclusions from my sources. A deductive analysis based on the central elements of the ACF was employed in exploring the data as a fruitful guide to frame, make sense of, and to understand what I was told or read in the data. I opted to limit this thematic analysis to two sources, congressional hearings, and interviews (excluding newspapers and institutional reports); while newspapers and other documentation were used as contextual information, providing a landscape of the process. In the next table, I list the steps I followed in the analysis of the data.

Table 9 Steps to Data Analysis

Interview Transcription – Collating documents
Reading and first coding (pen and paper)
Uploading and Second coding process in Nvivo 10
Interpretative reading of transcriptions, coding and then clustering into themes. Iterative process that includes disconfirming evidence to enrich the data analysis
Presentation of themes in a narrative that include verbatim statements or paragraphs from sources, and subsequent interpretation and discussion of findings.

Source: own elaboration.

Transcribing the interviews was indeed the first and the most useful way to familiarise myself with the data and to recall the context of the meetings. My interviews were conducted in Spanish and I transcribed them in the same language. Once I completed the transcription, the first step was to print out interviews and then start open coding these documents in a pencil and paper style. According to Rubin and Rubin (2011), the coding process consists of: 1) recognising those sections from your data that give you "a better understanding of your research problem", 2)

assessing their pertinence; and, 3) explaining them in your own words. Codes were initially identified among texts, and when issues were linked to the same issue or topic, they were grouped together in analytical categories. The same excerpts could be labelled with several different codes.

In my analysis of data, a coding process was deductive, considering the components of the ACF as a theoretical framework. At first, I was coding interviews freely and the sections of the Congressional Hearings that corresponded to transcriptions of legislative sessions. The second round of coding was done using the Nvivo 10 (a qualitative data analysis software) organising the data in framework analysis matrices. One of the advantages of working with Nvivo was that it helped organise the material according to the source and codes. This simplified the visualisation of codes and facilitated the process of grouping them together into sub themes and themes. I uploaded a copy of the interviews and congressional hearings to Nvivo and then chunks or texts that captured something meaningful were iteratively tagged under a code. This process resulted in either confirming or adding new codes to the first round of the coding process. The analysis of interviews and congressional hearings yielded 519 codes, which were organised into nine themes, which were related to the components and premises of the ACF regarding coalitions, stable parameters, and opportunity structures among others.

Table 10 Set of Themes Identified

Reform Agenda: background, stages and results
Identification of coalitions: competing views about the reform
Dynamic and evolution of political coalitions
Public opinion and mobilisation of political resources
Technical knowledge to build consensus
Influences of policy brokers on the process of change
Political participation and contestation within the health sector
Presidential powers and strategies of influence
Electoral system and distribution of political forces

Source: Own elaboration

These themes are the basis of my findings, which are explained in a detail in chapters six, seven, and eight. While the transcriptions and data analysis were done in Spanish, a selection of relevant quotes from my sources was carefully translated (Van Nes et al. 2010), and placed in the following chapters to create a narrative of the policy-making process. Each quote ends with the

identification of the interviewee by his or her surname and the year of the interview. The quotes from congressional hearings and newspapers are also indicated at the end of the quote.

5.5 FIELDWORK EVALUATION

On reflection, I think the most difficult informants were parliamentarians, because, as their assistants said to me, they had very busy schedules and no time to waste on other things. Although I managed to get a couple of interviews at Congress, they were not very useful because these meetings lasted less than 20 minutes. I had to travel a couple of hours to get to the Congress (which is not in Santiago). Then, the appointments were delayed by around one hour in both cases, and the actual interviews were less useful in terms of information compared to the rest of the meetings. They scarcely addressed my questions, instead talking about whatever they wanted, or lecturing me about the current political circumstances in the health sector. I had to ask politely, several times, if we could go back to the previous years. I asked many probing and repeating questions, but it was quite difficult for me to face and manage the ego and the 'self-promotion' of these particular interviewees. I am aware that these responses were a way to, either avoid answering specific questions or because they wanted to make their position of power clear. I would say that by doing further interviews, I learnt more about how to deal with these situations and I became more confident in controlling the agenda of the meeting. In contrast to my interviews with the deputies and parliamentarians, in my interview with former President Lagos, he attentively responded to the questions I was asking. My main concern for this particular interview was how to make the most of those thirty minutes and how to manage my questions smartly, given the fact that Ricardo Lagos is well known as a statesman with an irascible character.[25] My concerns were based on his strong personality, but I was surprised as he was very interested in what and why I was doing this research.

[25] His strong personality is always linked with a political interview programme in the Chilean TV, in 1986; where he publicly defied Pinochet.

I also included some people who had less visible positions, such as advisors or researchers in think tanks, who were not always on the front line, but who had privileged knowledge or information and played a significant role in policy-making as experts. They had expertise and were in those positions as technocrats, but they were very often also part of the Chilean elite as they belonged to the upper-middle class who attended traditional schools and universities. They provided me with more details or with unofficial accounts about what happened between politicians and the tone of these conversations. These interviews were by far the most useful and relaxed ones because they were less focused on explaining themselves and more focused on the process. They also helped me to identify other relevant people, whom I had not initially considered at the beginning of my fieldwork or to discard actors who were not actually very important. This was particularly true in the case of the deputies, who were included in my original list. However, after several interviews I realised that their role was not as relevant as I had initially thought, as the most important decisions were made outside the Chamber of Deputies.

My final reflection on the interviews is that for me, interviewing executives from the private health companies was a challenge. This was because I do not share any of their ideological views and because I believe these companies are quite responsible for the unfairness of the Chilean health system. I had to prepare myself to not show my own prejudices in the conversations. I think this worked well as they felt comfortable telling me their views and I felt confident asking questions. Also, they presented me with some ideas that challenged my previous conceptions of the business. For instance, the research director of the ISAPRES Association, Gonzalo Simon, said me “everyone criticised the private sector because we did not do this or that, but the thing is that nobody takes seriously the responsibility to improve the public health system which covers more than 70% of population.”

Despite this, there was an incident at the end of one meeting that made me reflect on my role as a researcher. One of the respondents asked me if I would be interested in doing consultancy about the future of the ISAPRES. I replied with a vague answer, because I did not want to break the amicable tone of the interview. Nevertheless, I do think I faced an ethical dilemma, because this proposition involved a payment that could somehow affect my independence as a researcher. On the other hand, I do not think that this person was looking to influence my views about the private sector and my reflections on my thesis, given the limited effect it would have on this policy process. I think that he wanted to know more about the possible effects of the reform and to take

advantage of my previous knowledge. Nevertheless, it was a situation that made me reflect on my own values and behaviour as a researcher when confronting potential conflicts.

Moving onto the limitations of my fieldwork and data collection, I failed to obtain interviews from right-wing politicians. Unfortunately, none of the senators on the health commission from the *Alianza* consented to being interviewed despite multiple attempts. I previously acknowledged that I ceased recruiting informants when I stopped getting new information from the interviewees; however I was open to incorporating additional interviews from these particular informants. Unfortunately, this did not happen even though I sent several requests just before the start of my data analysis. I also failed to interview two other senators from the *Concertación* who were part of the health commission. Edgardo Boeninger, passed away in 2007; and Mariano Ruiz Esquide, because his old age, was not doing public activities at the time of my fieldwork, I was told by his assistant. I am aware that the lack of these interviews, as well as the ones with the former Minister Bachelet and Senator Matthei, represent a limitation of my research. In order to mitigate this, I tried to gather all the documentation (books, articles, press notes, legislative documents and policy reports) available that could allow me to understand their positions and opinions about the reform processes.

5.6 SUMMARY

This chapter has presented the research design used in this thesis, including an explanation of the data collection and analysis, and a reflexive account of my fieldwork, situating this study within the qualitative strand of the ACF works. In looking at the policy process, I adopted a qualitative case study approach to analyse the meanings and significance of the Chilean health reform through the lens of the Advocacy Coalition Framework and informed by international literature of health policy reforms, two main techniques of data collection were employed in this study: semi-structured elites interviews and documentary sources. After conducting 26 interviews with political and technocratic elites and the review of documents, data gathered was deductively analysed based on a thematic analysis and 9 themes emerged related to the theoretical framework. Based on the analysis of the data, the next three chapters present the findings of this study.

CHAPTER 6 THE EVOLUTION OF COALITIONS WITHIN THE HEALTH POLICY SUBSYSTEM

6.1 INTRODUCTION

Last chapter presented the research design and the techniques used on the collection and analysis of data, which was gathered from two main sources, i.e. semi structures interviews and the examination of secondary sources. The findings of this analysis are explained in the three following chapters.

Based on the Advocacy Coalition Framework, this chapter begins with the identification of coalitions during the health reform process, explaining the beliefs systems and viewpoints of the actors that were engaged in the discussion, distinguishing two main phases of interaction. This chapter will shows that instead of a rigid scenario, there was an evolution of coalitions throughout this process, as the health reform unfolds. The main relevance of this dynamic configuration of coalitions is to understand how policy change was achieved. The presentation of the data includes quotes from the elites interviews, and excerpts of the transcriptions of congressional hearings and newspapers, indicating at the end of each quote, the surname of the interviewee or the documentary sources.

The structure of the chapter is as follows: in the first section, the main principles that guide the reform are introduced. The second section identifies the coalitions during the first period of the proposal discussion, and thirdly, I explore the fusion of these coalitions in the second legislative stage in the Senate. Last section summarise the findings regarding the coalition structure.

6.2 THE REFORM AGENDA

Until the *Concertación's* third term in office, there were no significant attempts to restructure the health care sector. One of the reasons for the lack of structural reforms in the social sectors is explained by an ex-advisor of President Lagos:

> *"This centre-left group sought to avoid conflicts and polarisation after the return to the democracy, preventing any change that could destabilise the political system, creating a similar environment of conflict as it happened during the Unidad Popular. The fear from the*

past prevented structural changes to the political and economic model implemented during the dictatorship" ***(Ottone 2013).***

Other respondents suggest that fear was not the only factor preventing reform and the fact that *Concertación*'s members enjoyed a comfortable position once they had achieved political power also played a role,

"The question among the Concertacionist was: why we should change something that is highly convenient? People in the centre-left built political power and they were also beneficiaries of the market-oriented economic model, so there were no incentives to change the model" ***(Davila 2013).***

However, the consolidation of the *Concertación*'s power after a decade in office created an opportunity for President Ricardo Lagos to make reforms to the health sector. During his presidential campaign, President Lagos emphasised his commitment to implementing sectorial reform to fix the deficiencies in the health system. Even though health care outcomes in Chile were good in comparison to other Latin American countries, there were some critical unsolved issues, such as the unregulated market of ISAPRES and the deficiencies of the public health system. In an interview with me, President Lagos asserted that considering his previous experience as a Minister of Education and Infrastructure,

"I was able to recognise the changes needed by Chilean society. After the developments we made in infrastructure, the judicial reform and housing programmes developed by Aylwin and Frei, I felt that we, the Concertación, were lagging behind, and we needed to do something about protecting against the risks related to the health and well-being. That was the reason for starting the health care sector reform" ***(Lagos 2013).***

As some interviewees noted, Lagos' motivation and knowledge about health were also influenced the people surrounding him with expertise in Public Health, such as his father-in-law Hernan Duran and his friend Hernan Sandoval (who was later nominated by Lagos for the position of executive secretary of the health reform commission).

One member of the legal team for the Health Ministry describes the essence of the reform, saying that:

"When you are in law school, they teach you that there are two different types of human rights: civil/political rights and social/cultural rights. The first ones are guaranteed and the second are not. Somehow it was very radical to guarantee a social right that is not usually ensured by the Constitution" ***(Romero 2013).***

This idea represented the core of the social democratic agenda of President Lagos, who sought, in contrast to the individualistic approach of the dictatorship, to redefine health care as an entitlement. The most controversial new proposal had a redistributive component in which wealthy users would subsidise the AUGE Plan for the poorest. Specifically, President Lagos proposed a set of bills that comprised of five main policies:[26] a regulatory framework for ISAPRES (two bills), new managerial and administrative guidelines for public authorities, the Plan AUGE, and the Funding Law (as part of the Law 19.888). The components of the reform represent the range of issues that were part of the debate. As noted before, it were the last two policies that caused the most disagreement between coalitions, given that both involved the transfer and redistribution of economic resources. In the next section, I identify the coalitions around these policy changes.

6.3 IDENTIFICATION OF COALITIONS: COMPETING VIEWS ON HEALTH REFORM

The identification of coalition was primarily guided by the various positions of actors based on the analysis of the data. It is worth noting that in general, there was no opposition to having a reform to the health system because there was a general understanding about the deficiencies of the sector, but the main disagreement was about the scope of the changes and the outcome expected of a reform. My data shows there was a clear separation of those committed to the reform – as the executive branch actors originally planned it – and on the other side, there was another group of actors who still wanted to have a reform, but they were against the plan elaborated by the Government for various reasons. From the analysis of their reflections founded in Congressional Hearings and other documents as well as the responses during the interviews, the division between actors was clearer regarding the outcome expected from the reform; and what

[26] The content of the reform is described in Chapter 4.

policies they were supporting in each case. According to the data, the process could be divided into two periods. The first period began in May 2000, when President Lagos announced the reform in his annual speech in the Congress until the reforms were passed from the Chamber of Deputies to the Senate in January 2003. The second phase started with the legislative debate at the Senate and ended with the enactment of the last reform, in May 2005.

At the beginning of the process, I identified there were four coalitions: the first coalition was the **reformer**, represented by governmental authorities; the second was the **radical** coalition, which had its support base in those actors who were seeking a radical transformation of the health sector. The third coalition could be named as **moderate** that included individuals who were keen to maintain the status quo; and fourth, the **neoliberal** who supported market-oriented policies and protected the further autonomy of the private sector.

In a second period, I identified the conformation of one coalition that I called **pragmatic,** which was framed in a scenario of plural participation between authorities, union workers, and professionals. These participants were also invited to the first part of the legislative process, at the Chamber of Deputies, where a very politicised debate continued, when several actors attended meetings to express their ideas and concerns about the proposal. At this stage, some of the coalitions supported or opposed different aspects of the proposal, based on particular interests and broad ideological principles that determined the views from each coalition. As it is explained by a former Minister of Health, Osvaldo Artaza,

> *"During the discussion, different alternatives about how to face health sector issues were proposed by actors, and several of them were very contradictory. We had proposals that went from a single insurance fund; a national health system; to a competitive system between insurers, and competition of providers. We could say that the NHS model, a state model unified in its functions, funds and the provision of services, to a proposal with a multi-insurance providers competition. It goes to A to Z, so to speak"* ***(Artaza 2014).***

Members' coalitions and their main beliefs about the health sector are explained in the following sections.

REFORMER

This coalition was comprised of governmental authorities that sought to carry out an extensive reform of the health sector but maintaining the dual structure created in the eighties. The main goal for **Reformers** was to strengthen the capacity of the public system, providing better access, quality, and financial protection for all citizens, and to introduce a stronger regulation framework for the private sector. A solidarity goal would be mainly reached through the Compensatory Fund between ISAPRES and FONASA. The proponents of the health reform were mostly people from the executive branch, led by President Ricardo Lagos, the executive secretary of the committee Hernan Sandoval, the second and the third Minister of Health, Osvaldo Artaza and Pedro Garcia. Other actors were representatives of the Finance Minister and members of the Congress from the *Concertación,* who supported the proposal, advisors within the minister, and think tanks closest to the centre-left pact.

In June of 2000, a Committee of Ministers was formed to ensure that the proposal was coherent at all ministerial levels. This committee was comprised of the Home Office (Minister Ricardo Solari), the Secretary General of the Presidency Ministry (Minister Alvaro Garcia), the Ministry of Health, (Minister Michelle Bachelet) and, the Ministry of Finance (Minister Nicolas Eyzaguirre). This inter-ministerial committee was responsible, for instance, for discussing the guidelines and basis for the Primary Care Law (*Estatuto de Atencion Prim*aria) with the health union workers, before it was submitted to the Congress.

An important role was played by the team from the Finance Ministry led by Marcelo Tokman, who was, in practice, the second most powerful actor after the President, given the fact that the majority of public policies regarding the use of public funds required the approval of this Ministry. Their role was to translate the political goals of the governments into feasible policies. As one member of this team said,

> *"The idea of AUGE was previously defined, and the responsibility of the finance team was to translate the proposals into concrete policies…it defined the 56 pathologies covered by the AUGE, therefore we had to put a price and check if there were financial resources available, and to adjust the budget"* ***(Espinoza 2014).***

This team backed the reformers' views becoming a key factor to guarantee the support within governmental authorities. As some respondents suggest, if a project or bill did not have the

approval of the Finance Minister, it was unlikely that the project could pass. Tokman saw himself as a decisive negotiator, and he acknowledged that he was the only person who remained in the whole process from the very beginning as part of the inter-ministerial committee until the last bill was approved in the Congress:

> *"In fact, I think I was the only one who was at the first meeting when we constituted the reform team until we approved the last project in the Congress. People from other ministries were changing all the time"* ***(Tokman 2014).***

Although the reformers' team played a role in creating a cohesive group behind the initiative, the government also had internal disagreements into how to approach the reform, challenging the political parties discipline within the *Concertación*. This was reflected in the opposition from its authorities in charge of the reform, specifically the first Minister of Health, Michelle Bachelet, whom I include in the radical coalition. Hernan Sandoval said

> *"I was aware of the Bachelet's opinion against the reform, but for me: my focus was to go ahead with the presidential mandate, pushing forward the reform. However, Bachelet did the opposite, postponing the reform during 2001…"* ***(Sandoval 2013).***

President Lagos sought to end the conflicts between factions within the Executive (Bachelet vs. Sandoval) and consolidate a unified position on the reform through a cabinet reshuffle during January 2002. He appointed a DC militant, Osvaldo Artaza, as the new Health Minister with the mandate to submit the bill to Congress within the next three months and to construct a closely-knit network of support around the reform. With this change of authority, it was the end of a period of immobility of the reform, and the beginning of the legislative phase of the reform, having an executive team, all committed to the Lagos' views.

RADICAL

Against the reformers, there was the coalition I call **Radical**, which was composed of a group of actors from the *Concertación*, who expected a more radical transformation of the health system, including the elimination or the reduction of the minimum expression of private institutions in the sector. People or organisations in this coalition are the First Minister of Health, Michelle Bachelet, congressional representatives from different parties, *Colegio Medico*, and health workers unions.

The fact that Michelle Bachelet and her collaborators from the Socialist Party rejected the idea of the reform was an obstacle for the Executive Committee led by Hernan Sandoval. According to Hector Sanchez:

> *"Bachelet was a classical socialist, and she did not have the interest in implementing the reform in the health sector; and with Sandoval in the commission, there was a cohabitation –not pacifically– of almost two ministers" (**Sanchez 2014).***

Another interviewee confirmed that the delay of the reform was intentionally promoted from the Minister, because,

> *"They were not convinced about the model proposed… and Marisol Barria, Hernan Monasterio from FONASA had the reform totally blocked because they did not believe in it" (**Romero 2013).***

> *"There was ideological opposition in some areas. Curiously, the socialists thought that as this model (the reform) was promoted by the World Bank, it was the expression of neoliberalism, the revenge of capitalism; and that is what they presented…there was an enigma because I think this reform was pro-socialist, as the aim was to strengthen the state in the public sector. There were socialist doctors who declared themselves against this reform because it was going to reduce their salaries, and they said so" **(Jimenez 2013).***

While the elaboration of the reform draft was assigned to the commission led by Sandoval, in parallel Minister Bachelet opened a debate inviting a number of actors to roundtables in different cities, to discuss the general ideas and plausible guidelines for the proposal. The period of Bachelet as Minister was not seen as a very productive time for the government goals because there were not concrete outcomes regarding the reforms' content. Nevertheless, the delay for this reform is subject to interpretation in the interviews. While the majority of interviewees suggest, this delay was caused by the personal conflict between Bachelet and the executive secretary Hernan Sandoval. However, an alternative explanation is raised by a couple of the respondents, who mentioned that the delay might be explained by the fact that there was a parliamentary election at the end of the second year of the Lagos term (December 2001). Also, in that scenario, it was very unlikely that the government would be interested in jeopardising the results of the election, creating

more divisions between the factions of the Socialist Party represented by Bachelet and the rest of the *Concertación* parties. Thus, the delay in the submission of the bill could be explained as an electoral strategy from the government and not necessary as a boycott from Bachelet to Sandoval's plan.

In this group, I also include the medical professional and health workers, who saw the reform as a threat to their working conditions and as an attempt at a full privatisation of the health sector. At that time, Colegio Medico was lead by Enrique Accorsi[27] until 2001, and then by Jose Luis Castro from 2002 to 2008, and it represented around 15.000 doctors[28]. He argued that the state would finally be subsidised for-profit providers as if public health services could not provide the treatment of the AUGE Plan, FONASA had to buy services in the private sector.

Some respondents explained that another argument from the Colegio Medico against the governmental plan was the defence of their autonomy and the right to decide about what treatments should be prescribed. This autonomy is something that the AUGE Plan would change as the Ministry defines protocols for medical attentions, limiting doctors' discretion in decision-making. The former Minister Artaza noted the double face of the discourse from Colegio Medico,

> *"The Colegio Medico was not against the reform because of the unfairness of the private sector, it was because they were afraid of losing power; that meant a regulation of the medical practice, and the control of the power of the decisions of doctors because the list of treatable diseases was defined by the AUGE" (**Artaza 2014).***

In the same line, during the parliamentary discussion, a congress member from the Socialist Party and a doctor, Deputy Fulvio Rossi who defended the reform stated,

> *"This is the moment to produce the reform that the people need…Not the one needed by Juan Luis Castro [President of Colegio Medico] or Esteban Maturana [CONFUSAM Leader], not for us [the congress representatives]. It is a solidarity reform that Chileans needed, especially the poorest... 66 percent of medical appointments are in the private*

[27] After his presidency at *Colegio Medico*, Enrique Accorsi won a seat in the Congress as a deputy from one district of the Metropolitan Region.
[28] Data from *Diario La Segunda* (10 May 2002).

sector, providing services just for 20 percent of the population; and just a third of those appointments are in public hospitals, which deliver attention to 80 percent of the population. I ask to doctor Juan Luis Castro: Are you going to stop working in private clinics and medical centres when you are doing strikes in public hospitals? It's easier for you to not go to work if you don't have to pay for the consequences from your pocket, but you are manipulating the health of the poorest…" ***(Deputy Fulvio Rossi, Congressional Hearings Nº 19.966).***

This point was at the centre of the conflict between the doctors and the reformers, autonomy versus control that could have affected the income gained from private attentions. A member of the ISAPRES, also confirmed this idea adding the factor that doctors worked most of the time –if not exclusively– in private practices and clinics, which is a highly convenient scheme in economic terms. Andres Tagle noted that,

"The Colegio Medico always wanted to defend the free choice [of patients to choose their doctors], because of the arrangement they have with the private medicine" ***(Tagle 2013).***

An advisor from the DC, Manuel Inostroza, explained this contradiction, highlighting the ideological conflict,

"Juan Luis Castro (from Colegio Medico) represented an extremely ideological opinion, a radical view of the reform; they had this ideological stand…but contradictory, they were thinking as doctors, but doctors from the right because they were concerned about their income, and they saw AUGE as a threat" ***(Inostroza 2013).***

However, the position of the Colegio Medico was not shared for all medical professionals who were part of this organisation. A think tank organised by doctors, who were also affiliated to the Colegio Medico, "Doctors for Chile" *(Medicos para Chile)* represented a faction that held more neoliberal views within the community, felt that the *Colegio Medico* was highly politicised, and that

they did not represent the general views of doctors properly. The president of the think tank, Emilio Santelices[29] explained,

> *"We, being doctors from the opposite side –to the Colegio Medico- were in total disagreement; because we think that the improvements in equity, opportunity, and access, were attributes expected in any health system. In fact, it was suggested by institutions such as World Bank and WHO, and this reform was on that path" (**Santelices 2013).***

However, the capacity of influence of this group, and, in general, doctors who were not represented by the directive of the *Colegio Medico*, were not strong enough to challenge the monolithic representation of this traditional association. In the case of health workers unions, one of its leaders said that,

> *"The reform may create an uncovered privatisation because if the public system was unable to provide the AUGE requirements, the state should have to transfer economic resources to the private sector, paying ISAPRES for the services that the public system were unable to provide" **(Maturana 2014).***

Nonetheless, for the municipal health workers organisation (*Confederacion the trabajadores de la salud Municipal*-CONFUSAM)[30] led by Esteban Maturana, it was in that sense, different from the interest of *Colegio Medico*, because most of them worked exclusively in public institutions, in contrast with doctors who worked half of their time in private clinics and practices. Their concerns about the reform were basically how they could maintain their entitlements and get extra benefits from the reform within the public system, as well as an increase in budgets for hospitals and primary centres to improve their working conditions. In my interview with the President of CONFUSAM, he stated very clearly that these were the most important goals for his association, i.e. to achieve the best job contracts they could get within the public administration.

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[29] Emilio Santelices ran as a candidate for an election for president of the Colegio Medico in 2002, but the socialist Juan Luis Castro defeated him.

[30] CONFUSAM was comprised of 12.000 members from municipal health workers. CONFENATS gathered around 60.000 hospitals workers and administrative personnel.

Other actors in this coalition were members of the Congress, who had a political affiliation with the *Concertación* parties and opposed the reform because the reform would not have solved the deficiencies of the public system. Part of this group was known as the "*Bancada Medica*" composed of deputies and senators who were mostly doctors, such as Patricio Cornejo (DC), Enrique Accorsi and Guido Girardi (PPD), Carlos Abel Jarpa and Alberto Robles (PRSD) and the Senators Mariano Ruiz Esquide (DC), and the economists Carlos Ominami and Sergio Aguilo (PS). Additionally the connections between Colegio Medico and deputies from *Bancada Medica* made the process even more difficult because they were defending the positions of the professional association.

> *"They were not a political party; they were transversal. The Bancada Medica was against it -the reform- and there were people from all parties. They did not like this idea of having external requirements for the public sector. They also did not like that the Superintendencia [a regulatory agency] had control over the public system…"* ***(Viera Gallo 2014).***

It was in that stage the two deputies who belonged to the Bancada, Accorsi and Girardi voted against the reform, provoking wide disappointment within the *Concertación* and President Lagos himself.

> *"There were people from the left that said this reform was neoliberal because you should not have protocols…and I said then: how can I make estimates [about money needed]? In the end, the dispute was with the doctors within the Concertación because there were a number of them in the Congress, for instance, Girardi, who said everything was wrong. In the end, they had to accept that because I was the president…in the Socialist Party there were people that dislike the reform but nobody dared to reject it"* ***(Lagos 2013)***

Girardi explained his position to me and said,

> *"I talked with the President; I talked with Lagos… at that time I was President of the PPD, my party...He was very upset with me, and I said to him that I would vote against the project…because of its consequences. I thought this project would emphasise the curative approach to the public health (instead of a preventive one). Secondly, it would be a depredation of the system by ISAPRES. And third, this reform would mean the*

privatisation of the public health system…That is why I voted against the reform in the end" ***(Girardi 2014).***

An interviewee from the DC, who worked within the legal advisory team, stressed that,

"The most leftist members of the Concertación did not understand that the reform was progressive, and this could be an example of other reforms on social sectors with similar goals" ***(Romero 2013).***

MODERATE

A moderate coalition was the one composed of politicians and parliamentarians mostly from the Christian Democratic Party (DC). They defended the structure of the mixed system, but they were also willing to accept some modifications proposed to the health sector as long as the reform did not affect areas such as taxes, financial resources, and costs. Alejandro Foxley, member of this party and former Ministry of Finance said in a press note,

"The Christian Democratic Party is against everything that means to touch middle-class incomes" ***(Senator Alejandro Foxley quoted in La Segunda, 14 May 2002).***

Specifically, the debate was focussed between regressive versus progressive taxes, as they said it could affect the middle-class. Regarding the content of the proposal, they stated that the AUGE Plan was a good idea, but it should be implemented in a gradual way for two reasons: 1) because the public sector was not prepared to provide attention for a large number of diseases at once, and 2) because there were not enough resources to start the programme immediately. They also strongly rejected any attempt of taxes increases as a way to finance the reform, and that the transfer of contributions from ISAPRES to FONASA became a key issue of debate within the DC. Specifically, for senators such as Alejandro Foxley and Edgardo Boeninger[31], who claimed that any intervention into individuals' contributions in the private insurance companies was anti-

[31] Once the reform reached the Senate, the role as an opponent of Boeninger changed and he was the key person for the reform to articulate support in the Congress

constitutional, and that would be a catastrophe for middle-class citizens as they would have to pay the costs of the AUGE Plan via taxes.

The institutional Senator Edgardo Boeninger and Senator Alejandro Foxley presented a document approved by the economic committee of the party in May of 2002, in which they explained their position about the health reform. This document was published in a Sunday edition of one of the most important newspapers to disseminate their views about tax redistribution, where both Christian Democrats stated,

> *"We do not think it is compatible with a comprehensive approach to solving a national problem to propose a redistribution of resources for the middle class to the public sector...[the reform] must have a constructive approach of convergence and solidarity of the public and private subsystems…"* ***(Boeninger and Foxley's Document published La Tercera, 05 May 2002)***

Even though the senators had some internal support within the party, as the document was subscribed by other party members within the Congress such as Hosain Sabag (Senator and Vice President of the DC, Pablo Lorenzini (Deputy), Andres Zaldivar (President of the Senate) among others; there was an internal dispute with other members of the DC. For instance, Senator Ruiz Esquide, who supported radical views, rejected the document elaborated by Boeninger and Foxley saying that their declaration did not represent the position of the DC.

> *"The document approved by the economic committee of the party, doesn't have the support of the council neither from the health committee [of the party], so it is not the official view of the party. They are isolated…"* ***(Senator Mariano Ruiz Esquide quoted in La Tercera, 05 May 2002)***

Moderate views also held by parliamentarians who defended larger companies who were threatened directly and indirectly by the reform (Law 19.888), such as the wine and Pisco [grape brandy] producers and mining companies. The AUGE Plan and Chile Solidario were included in the proposal that established an increase of taxes for alcohol and tobacco; and was strongly opposed by those parliamentarians defending commercial interests. Particularly, it was the case of the DC Jorge Pizarro, a Senator for the 4th region in Chile, which is the district of Pisco production, who argued that tax rises could be a disaster in economic terms for the alcohol producers and

international traders, increasing costs, unemployment levels and economy productivity of the zone.A statement from Senator Pizarro in a newspaper, stated,

> *"I am against the specific taxes, as I said to the President -Lagos- last Monday. I am not going to be compelled to vote in favour of taxes that could affect those activities that need our support"* ***(Senator Jorge Pizarro quoted in La Tercera, 10 June 2003).***

NEOLIBERAL

Lastly, the right-wing political parties formed a coalition with private insurance companies, who supported principles of the neoliberal model and the structure of the socio-economic model developed under the dictatorship. They were against the reform proposed by the Government because 1) it would increase the costs for the private sector due to the cross-subsidy to the public sector and 2) they were concerned about the scope of the new regulatory framework and its effects for private providers' profits. Similar to the moderate coalition, neoliberals rejected the alternatives for funding proposed in Law 19.888, arguing that it would have an impact on the poorest segments of the population, which according to the UDI, was the electoral basis of the party. They claimed that the government should increase public expenditure without raising any taxes that could affect their voters.

In the case of the ISAPRES Association, they had a very well organised group created to defend the interests of the insurance companies, composed of people who were previously involved in the Ministry of Health during the dictatorship, which also had linkages with right-wing parties. Andres Tagle, for instance, was a former vice-president of the Association, member, and electoral expert of the UDI party, who explained to me that the situation of these companies with the reform was very problematic,

> *"All the restrictions imposed by the Congress, about the pre-existening conditions and the limits for price modifications, put ISAPRES in a very bad situation, making it almost impossible to sign a contract. We had everything against ISAPRES because they had said to the public opinion that this question –health care– was free and they thought it was legitimate"* ***(Tagle 2013).***

However, at the same time, informants from this group said the AUGE Plan was not a threat to private insurance companies, as their ISAPRES contracts already provided most of the services defined in the Plan as Tagle expressed,

> *"Regarding coverage and opportunity, it was rather a problem for the public sector, because in the ISAPRES you always have guarantees assured by a legal contract"* ***(Tagle 2013).***

Interestingly, at the Lower Chamber, the neoliberal coalition was not the most important obstacle for reformers. Even though their members were invited to attend the health commission sessions regularly to expound their views, some respondents commented that the right-wing sector was smart enough to realise that the real problem for the government would come from the clash of interests within the *Concertación*. In that scenario, they did not get involved as they did in the next phase of debate in the Senate. Artaza mentioned that during that phase,

> *"The Right stood back and watched…as they soon realised that their interests would not be affected and because the government had internal sources of conflicts, they did not spend efforts to challenge the reform in the Lower Chamber" (****Artaza 2014).***

The following table shows the identification of most relevant actors of the policy process in each coalition that were frequently mentioned in the collection of data and the examination of documentary sources:

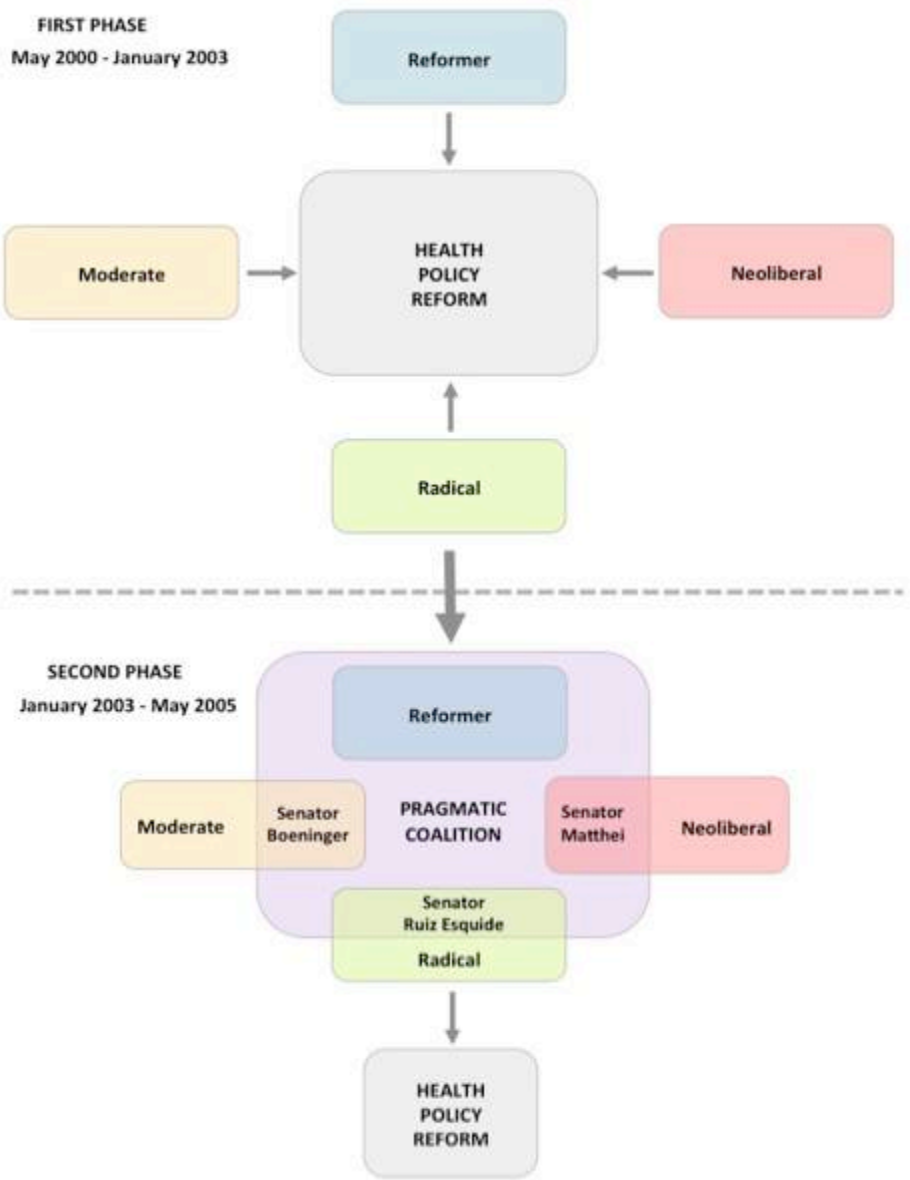
Table 11 Coalitions' members and policy core beliefs in the first stage

POLICY CORE BELIEFS	REFORMERS	RADICALS	MODERATE	NEOLIBERALS
Groups affected by the reform	Vulnerable sectors of the society: the poorest, middle class, elder population, and women.	Middle and poor class/ professionals and workers on health sector	Middle class/ entrepreneurs sectors affected by taxation raises and funds transfers	High and middle classes, entrepreneurs interests Poor segments as voters
Aims	They seek to provide universal access to health for, increase regulation for private sector, and strengthen the capacities of the Ministry of Health	They want a radical change, eliminating or reduce to the minimum the functions of the private sector. They also expected to preserve their entities such as working conditions, autonomy and free practice.	The transfer of money from ISAPRES to FONASA might affect affiliates in the private sector.	They believe in the market as good provider, defending free choice, and rejecting regulation, tax increase and cross subsidy. Public sector is inefficient. The reforms may increase the cost for private insurers and therefore an increase of the prices of ISAPRES affiliates.
Problems/ issues	Unfairness and inequalities in the current health system.	Privatisation of the system Autonomy and income of doctors. Income and work benefits of health workers	Negative consequences of governmental intervention in the private sector	State is inefficient as administrator of public resources
Division of authority between market and the government	Shared, but strict regulation policies for market	State control	Shared	Free market
Actors/organisations	President Ricardo Lagos Health Reform Commission Hernan Sandoval 2nd Health Minister Osvaldo Artaza (DC) 3rd Health Minister Pedro Garcia (DC) Members of Centre-Left wing Political Parties (the Concertación) Think Tanks (Cieplan, Chile 21, Expansiva, CED)	1st Health Minister Michelle Bachelet (PS) Medical Association (Colegio Medico) leaded by Juan Luis Castro A group of Centre-Left deputies and senators gathered in what was known as *Bancada Medica.* Health workers unions led by Esteban Maturana	A group of militants within the Christian Democrat Party (DC), such as: Alejandro Foxley, Edgardo Boeringer, Jorge Pizarro	Andres Tagle, Gonzalo Simon, Rafael Caviedes, Hernan Doren from ISAPRES (Private Insurance Companies) Right-wing Political Parties Renovacion Nacional (RN) and Union Democrata Independiente UDI) Fundacion Jaime Guzman y Libertad y Desarrollo (Think Tanks)

6.4 EVOLUTION OF POLITICAL FORCES: A PRAGMATIC COALITION

The coalitions' scheme explained in the previous section was transformed when the bills were approved by the Lower Chamber in June 2003 and passed to the Senate. The next table presents a diagram with this evolution:

Figure 3 Diagram of evolution of coalitions by phase



Source: Own elaboration

I called this as a pragmatic coalition, which is the result of the fusion of reformers with specific actors from other coalitions; which have the capacity to exclude other coalition members that were seen as an obstacle to the reform. In this new coalition formation, I included some senators who were part of the health commission: Mariano Ruiz Esquide and Edgardo Boeninger (DC); Evelyn Matthei (UDI). Although the composition of this committee was of five members as regulated by the Senate procedures, which also included Jose Antonio Viera Gallo (PS); Alberto Espina (RN); it was constantly repeated by my interviewees, that the first three senators were the key persons that led the discussion. There were also think tank members that supported the legislative work on technical grounds, and governmental authorities. At the beginning of this phase, a third Minister of Health, Pedro Garcia, was appointed by Lagos contributed to the consolidation of the pragmatic coalition. Analysing the composition of this coalition, some issues emerged from the data analysed. First, key persons from each coalition were engaged and committed to passing the bill in the Senate. Reformers were able to consolidate a group of work that, despite the specific differences about the content of the reform, were willing to collaborate, adapting their views from their previous coalitions. As it was explained in the interviews, people such as the two senators from the DC, Mariano Ruiz Esquide and Edgardo Boeninger, were part of the first phase of the debate of the radical and moderate coalitions, respectively; and Evelyn Matthei32 was part of those who rejected the proposal based on the neoliberal principles. According to the interviewees, after the Compensatory Fund was eliminated of the agenda, as this was one of the most controversial issues, the bill was passed and the economic support was assured. At the end of the discussion, Senator Ruiz Esquide commented,

> *"It is very valuable that this initiative was approved by a majority, given the difficulties, complexities and public debate, this made it difficult to deal with. As an example, it is worth noting that the reform of 1952, which created the National Health Service, took more than six years before it was approved…It was not a simple transaction; it was a reasonable consensus about what is possible between senators who have different*

[32] She was elected as independent but with the support of the UDI in 1998. She was previously member of Renovacion Nacional party, but she quits after a political scandal of hacking a telephone conversation of the former Chilean President Sebastian Piñera in 1994.

perspectives to see society" ***(Senator Mariano Ruiz Esquide, Congressional Hearings Law No 19.966)***.

Senator Boeninger highlighted the concessions made and the quality of the work produced by the group of senators at the end of the policy process when the reform was approved,

> *"The original project included the creation of the compensatory fund for both FONASA and ISAPRES. As we know, that proposal was no longer supported and did not count with political acceptance, and the executive decided to remove it from the discussion to give us more time to evaluate an alternative formula…to gather the votes for its approval"* ***(Senator Edgardo Boeninger, Congressional Hearings Law No 19.966).***

> *"I would like to emphasise the spirit and serious work of the Health Committee, and its enormous will to get to an agreement in what we were working long months for… this project, and the others as well, are potentially the starting point for a real revolution in health provision" (****Senator Edgardo Boeninger, Congressional Hearings Law No 19.966).***

At the point in which the reform was close to being passed, Senator Matthei also explained the reasons why she approved the project at the end of the policy process,

> *"I consider that the global project, as it was presented to the Senate today, with the guarantee of access and attention, with financial coverage for users in ISAPRES and FONASA, with no discrimination by gender or age in ISAPRES, is good and deserved to be approved by unanimity"* ***(Senator Evelyn Matthei, Congressional Hearings Law No 19.966).***

Hence, reformer coalition was finally able to build the consensus need it around these issues and to get the favourable votes of these senators.

The second characteristic of this coalition was the high level of expertise in different areas of its members, such as the knowledge about the health sector of the Senator Ruiz-Esquide, or Evelyn Matthei's prowess in economics, or Boeninger's command of politics. In the health committee, Senator Viera Gallo explained,

"We had to translate the guarantees offered by the State. In the beginning, the bill was too vague and, as I am a lawyer, we then introduced judicial precision…for instance, what means quality, what means professional attention, deadlines, free charges… I think we made important specifications in an original project that was very naïve" ***(Viera Gallo 2014).***

Thirdly, the designation of a new sectorial minister Pedro Garcia, replacing Osvaldo Artaza, was crucial for the approval of the reform. He was a DC, from the most conservative faction of the group and he was close to the Party leaders, which differed from the Artaza position inside the DC. He was able to coordinate the forces within the *Concertación* political parties and to extend ties to the right-wing senators. His goal was to articulate a consensus within the DC and, more importantly, to get the votes from the right. According to the respondents, he was seen as a good manager, with a good relationship with Sandoval, and he had the support of the DC president, Adolfo Zaldivar. But more importantly, it was his personality that helped to create a consensus,

"Pedro was the key person in this agreement. I think his role has not been recognised enough because he was brave and prudent to accept the criticisms…during the negotiation, he did not impose his views; he was reflexive and open minded…unlike the previous minister. He had the patience and the will to wait for the decisions of the parliamentarians" ***(Sanchez 2014).***

Garcia recognised that he was indeed very patient during the process, but he was able to manage the struggles between the actors adequately, mainly because he knew that he had the support of President Lagos and Sandoval, and the respect of the senators within the Commission, in particular from Evelyn Matthei, who was a crucial actor from the right.

Fourth, the exclusion of actors and one issue, in particular, was strategy to get a consensus. Radical views from Colegio Medico and health workers were excluded at this point. Although, representatives of the Colegio Medico and ISAPRES were invited to the public sessions as it was recorded in the Congressional Hearings, it seems that these invitations were more a symbolic procedure because a small group of the pragmatic coalition took the relevant decisions. While the Colegio Medico concentrated all its efforts to have influence in the process at the Lower Chamber, through an aggressive campaign in the media and the interaction with the *Bancada Medica*; in the Senate, despite the fact that they attended these sessions, they were aware that they had lost any

chance to modify the bill in its favour. Furthermore, there were episodes of strikes against the AUGE Plan organised by doctors and health workers associations, the leader of the CONFUSAM explained,

> *"We went to every session at the Congress, all of them…we fought constantly; we had the support of the deputies, such as Girardi, that were strongly opposed to the reform that Ricardo Lagos wanted to impose. The Bancada Medica gave us their support, but within the Congress, Ricardo Lagos finally took control and put discipline in the Concertación, because at the end, the reform was implemented because they had an agreement with the right-wing parties We had to recognise that we were defeated and that Lagos won"* ***(Maturana 2014).***

The exclusion of ISAPRES seems to respond to a different reason. Although, ISAPRES were permanently invited to the health commission sessions, I argue that they were no longer active participants in the debate because they did not have specific interests to defend. This happened after Evelyn Matthei said that the right would not approve the reform if the Government did not take the Compensatory Fund out from the bill. As such, the executive made the concession to ensure the feasibility of the rest of the package. In the Congressional Hearings it is stated that,

> *"Senator Matthei did appreciate the withdraw of the Compensatory Fund…because its inclusion would obstruct the chances to pass the bill. This withdrawal make it possible to get the votes from senators of the Alianza por Chile"* ***(Congressional Hearings Law No 19.888).***

According to a note in a newspaper, after the bill was passed, Matthei said,

> *"There were no winners or losers, but we made the best of the situation; we eliminated the worst thing…but we did not get everything because there will not be portable vouchers…"* ***(Senator Evelyn Matthei quoted in El Mercurio, 13 May 2004)***

Once the main obstacle for the right-wing political parties and the ISAPRES was eliminated, the private insurance companies did not have any other substantial battle against the government. Hence, it is possible to say that it was more like a self-exclusion than an intentional manoeuvre from the Senate. Sebastian Soto, advisor from Libertad y Desarrollo explained to me that,

"The Right soon realised that it was more convenient for them to support the reform because they had the options to shape it… there was a possibility to improve it, and therefore they agreed to approve it" ***(Soto 2014).***

All in all, this stage shows that some actors were able to modify their initial positions and to make sacrifices, after assessing whether the benefits would be higher than the costs if they reached agreements with former opponents. Hector Sanchez illustrates this idea, explaining why the government sacrificed the Compensatory Fund,

"They had a strategic view, and they said we cannot fail because we already spent all of our political capital on this reform, and the senators were thinking the same…therefore, they accepted to renounce the Compensatory Fund" ***(Sanchez 2014).***

This pragmatic coalition finally adopted a course of action that made the reform feasible to be approved in the Senate. Senator Viera-Gallo, emphasised the particularity of this reform,

"I have always said that this is an example of a law, that after a strong ideological confrontation, the discussion became practical. And the reform was approved almost for unanimity…that was strange, because it started like this was a world war" ***(Viera Gallo 2014).***

A negative view from one of the two deputies from the *Concertación* that voted against the reform, Guido Girardi explained that the decision of withdrawing the Compensatory Fund was rather a failure of the executive with negative consequences for the health sector.

"When President Lagos realised there was a possibility to fail because of the veto of the right-wing parties about the Compensatory Fund; He accepted to take this out to get, at least, some parts of the reform approved. I would say that they finally made a reform irrelevant, that did not affect ISAPRES at all…that is why I voted against the reform" ***(Girardi 2014).***

Instead of the reflection about the political costs, Hernan Sandoval explained that the reason to make the concession was also practical and based on the availability of resources. He commented,

"We saw that we would get 19 million from the transfer from ISAPRE to FONASA, but we also realised that AUGE Plan could bring an increase of more than 500 million pesos, so we did not really need the Compensatory Fund at that particular time. The fund had no sense in financial terms…I did not care about sacrificing three or four insignificant pesos [Chilean currency]… my position was: I am willing to sacrifice the monies, but not the principles" ***(Sandoval 2014).***

6.5 SUMMARY

The main target of this chapter was to identify the coalitions within the Chilean health policy subsystems, guided by the assumptions of the Advocacy Coalition Framework regarding the beliefs systems, and the behaviours of coalition members. Findings show that the process was clearly divided into two phases: the first one started with the announcement of the reform in May 2000 and ended when the first bill was passed from the Chamber of Deputies to the Senate, and then second phase lasted until the last bill was finally enacted in May of 2005. As it has emerged from the data, instead of having homogenous and rigid coalitions, findings provide evidence that there was an evolution of four coalitions in the first phase of the reform, to a pragmatic one that pushed the bills forward in the Congress.

The first part of the debate was characterised by the internal conflict within the executive branch, and with the early disputes within the Christian Democratic party, both disruptive factors for the reformers aim. Strong opposition from the Colegio Medico was also a feature of this period, but with less impact in the governmental agenda. In the second stage, during the debate that took place at the Senate, reformers were able to get the support of key people who were initially against the proposal. In the next two empirical chapters, I explore the strategies and resources used by these coalitions and the institutional settings as factors that framed the policy process, assessing their implications for the health reform.

CHAPTER 7 THE MOBILISATION OF RESOURCES AND STRATEGIES OF INFLUENCE

7.1 INTRODUCTION

The findings examined in the previous chapter showed a dynamic configuration of the coalitions that evolved along the policy process, from a competitive scenario to a collaborative one. As Jenkins Smith et al. (2014) points out, the utilisation and redistribution of resources are key factors for explaining the outcomes of coalition struggles; and power capacities are translated into the strategies that determine the course of the process. Therefore, this chapter looks at the strategies employed by coalitions during the two phases of the discussion, seeking to shape the policy process according to their goals.

This chapter is organised as follows: the first section explains the tactics developed by the four initial coalitions for the mobilisation of public opinion. The second section examines the technical team as a source of expertise and knowledge; and thirdly, I explore the role played by the policy brokers in the Senate. Finally, I conclude by summarising the findings regarding the strategies employed by coalitions in the policy process.

7.2 PUBLIC OPINION AND MOBILISATION OF POLITICAL RESOURCES

In the management of public opinion, the first two years of the Lagos administration were less intense than the second phase as there was a delay in the development of the proposal. In the newspaper coverage for the Bachelet period, I found that the recurrent issue in the press was the problem of waiting lists for FONASA patients. After this, President Lagos announced publicly that Bachelet had a very tight timeframe in which to solve this problem. She had simultaneous meetings with committees, local leaders and union representatives around the country, but, as noted previously, her period as a minister was seen by the respondents as fruitless, as she just sent one proposal, the patients' rights bill, to Congress.

The internal strategy developed by the reformer coalition was to move the discussion from the open debate implemented by Bachelet to the legislative context, where the Minister was in charge of the action plan. The second minister of the period asserted,

"During the first two years –of Bachelet–, the reform was in the living room with FENATS, Colegio Medico and ISAPRES. But the President, with a clever communicational strategy took the discussion out of this living room and put the lights on the parliamentarians to show how they were voting" ***(Artaza 2014).***

It was with the appointment of Osvaldo Artaza as Minister in January 2002 that the coalitions undertook a strategy of mobilisation. According to Dr. Jimenez,

*"During the period of Bachelet as a minister, there were spaces of debates and discussions to elaborate ideas and documents, but there were delays in the roundtables and no agreements at all… But this situation changed when Bachelet was replaced by Artaza" (****Jimenez 2013****).*

This strategy was translated iton two main activities: on the one hand, they launched a campaign to raise awareness about the meaning of the reform when the bill was sent to the Congress. On the other hand, they started to pilot the AUGE Programme in some municipalities in order to obtain visible results and to convince citizens about the feasibility of the program.

In order to generate social support from the citizens, the first activity of the reformer coalition was to mount a mass media campaign in April 2002. In this campaign, they took advantage of Artaza's profile: a very well known doctor with a "hippie look" (because of his long hair) who was the director of an important paediatric hospital in Santiago (Hospital Luis Calvo Mackenna). He became well known after performing the first surgery to separate Siamese twins in Chile in the mid 90's, which was widely covered by the press. After this episode, the citizenry knew him, as public opinion polls from that period confirm[33]. In order to disseminate the contents of the reform and get more support for the process, reformers tried to make the most of his personal qualities. People involved in the reform recognised that his figure was crucial to supporting the communication strategy. Artaza described a particular event,

[33] A survey of Centro de Estudios Publicos (CEP) of July 2002 and December of 2002 shows that Osvaldo Artaza support started with a 60% approval rating. However, once the process was more conflictive, his support decreased to 38% in six months.

"The day before the bill was sent to Congress, the President asked me to speak in a national broadcast message on television and radio, to announce that the reform proposal would be sent to Congress the next day. That was something historical, never seen before, as all the messages were delivered by the President…This time, it was a conversation between the doctor and his patients...about peoples' aspirations and expectations…and it was very successful because although people did not understand what was the AUGE about well, the polls surveys showed that everybody was supporting it, and that was decisive for parliamentarians to approve the reform. The government acted with an extraordinary audacity as they made a public campaign of a reform that was not yet approved … it had never been done before" ***(Artaza 2014).***

The second activity carried out by the reformer coalition was the implementation of a pilot of the AUGE Plan. The pilot started on August 1 2000, including three specific conditions for FONASA patients. Reformers' hopes were to gain empirical results to support the reform while it was being discussed in Congress, and, according to the former minister, to create a positive perception of the plan,

*"We were given the instruction to begin as soon as possible with a pilot [of the Plan AUGE] as people needed to understand how the reform would work in reality…a few days after the pilot began, the President could visit children and adults being treated, who were on waiting lists, hopeless. We gave the reform a face, eyes, nose, and a name. And I think none of this had to do with technical issues" (****Artaza 2014)****.*

The mobilisation of coalitions via public opinion reached its height during the weeks preceding the Presidential Message of 2002,[34] when Ricardo Lagos finally announced the reform. As a response to the reformers' strategies, radical coalition members, led by members of the Colegio Medico and the CONGRES[35], mobilised their troops in a more aggressive way than the rest of rival coalitions. Colegio Medico joined or co-organised strikes and demonstrations with health workers

[34] Every 21st of May, the Chilean president delivers an annual message to the Nation at the Congress in Valparaiso, giving an account of their achievements of the last year and their goals for the period ahead.

[35] The CONGRES was an organization composed by health workers unions from primary attention centres (*consultorios*) and health workers from public hospitals.

and, simultaneously, developed their own communication strategy with an aggressive attack on the reformers media campaign. Their aim was twofold: to discredit the governmental proposal and to announce an alternate programme, developed by the doctors association, called “A Comprehensive Health Plan” (*Plan Integral de Salud* - PAIS).

They invested their economic resources into hiring a slot on a regional –though not very influential– TV channel (*Canal 5, Quinta Region*), and also started an advertising campaign on public transport in Santiago with messages against the reform. Their critics focused on Artaza. Colegio Medico criticised his role because they saw him as a doctor who was supposed to be on their side, but who was against the interests of the medical association. A representative of the ISAPRE commented,

> "*Artaza was very effective in communicating the reform. I think he used up his prestige with the reform… he was a good player, and he was the target for the Colegio Medico darts*" ***(Tagle 2013)***.

A member of the government advisory team used the imagery of a battle and a hero to characterise the role of the former Minister,

> "*I think the Osvaldo Artaza's period was key in terms of disseminating the proposal to the citizens…when the AUGE publicity came out, it was a very risky option… sadly Osvaldo went out to bite the bullets publicly. But this phase was crucial and Osvaldo suffered the worst, the lower chamber was like a ‘guerrilla’…the costs he paid were high, but, in the end, we got what we were looking for, a reform that was accepted and supported by the citizenry*" ***(Romero 2013).***

The former minister Artaza said,

> "*There was an effort to diminish the reform's support. The Colegio Medico mounted a millionaire campaign, with ads on TV, on the public transport…All the Buses in Santiago had large stickers with phrases against the reform. They had pictures of me and they drew a big nose on my face, like Pinocchio, saying that I was a liar*" ***(Artaza 2014).***

Adverts And Flyers Colegio Medico

"The AUGE Plan is a fairy tale.

Fight for your rights to health. Get information at www.colegiomedico.cl and UCV Television on Thursday 22 pm"

"The AUGE is trying to cover the sun with one finger…It is imperative to change the AUGE…The reform proposed by the Government will not resolve the health issues of the Chileans. The AUGE will create first and second-class patients…The reform will stop doctors making the best decisions for the benefits of their patients.

Doctor: Let's defend the profession, yours and your patients' dignity. Get involved and fight for your rights…"

COLEGIO MEDICO

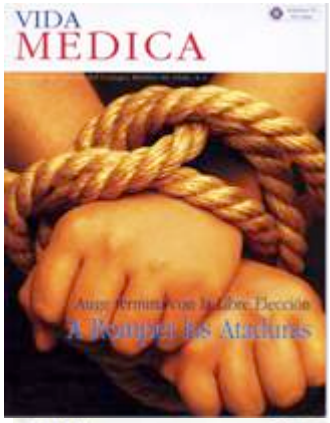
"Let's make a true reform"

Protest of *Colegio Medico* members, holding a poster with a picture of Pinocchio saying:

"[The AUGE] do not cover lung, liver bones and kidney cancer"

"*Vida Medica*" Covers - *Colegio Medico* Journal

"Because the AUGE is a fairy tale, let's do a real reform"



"The AUGE ends free choice, let's break the bonds"

"Doctor, with the reform your work is also in risk"

Figure 4 Graphical pieces of *Colegio Medico* campaign

Declaration *Colegio Medico*

COLEGIO MÉDICO DE CHILE (A.G.)

LOS MEDICOS Y LA REFORMA DE SALUD

Durante este año el país ha sido testigo de los esfuerzos del Colegio Médico por participar y avanzar en una Reforma de Salud que verdaderamente solucione los problemas que aquejan a la población.

Lamentablemente el Gobierno no ha respetado el compromiso de hacer una Reforma con participación de los usuarios y los trabajadores de la salud y optó por emitir los proyectos sin considerar los aportes de los especialistas, como es la representación en su oportunidad todas las Sociedades Científicas.

La constante negativa para abrir espacios de participación real y la imposición de la urgencia para la tramitación parlamentaria, han obligado a médicos y gremios de la salud a movilizarse para representar al país y a las autoridades la inconveniencia que la Reforma se sustente en el AUGE; un plan básico de salud orientado por criterios económicos y no por objetivos sanitarios.

Demostrando la unidad del mundo médico y su firme decisión de hacer una Reforma de verdad, solidaria y equitativa para la gente, a estas movilizaciones ha adherido por sobre el 80% de los colegas.

El Colegio Médico tampoco ha escatimado esfuerzos por el diálogo y por incidir con sus propuestas, difundiéndolas y elaborando indicaciones a los proyectos. Resultado de ello son algunos cambios importantes en el primer trámite legislativo, que se hace necesario sostener y profundizar.

El año termina con un creciente apoyo de organizaciones gremiales, sociales y de usuarios a la defensa de la salud pública, un gran desconocimiento ciudadano del AUGE y un negativo balance de su programa piloto, que demuestra que los beneficios para algunos pacientes son en desmedro de otros.

Apremiados por los tiempos legislativos que inexorablemente deben defenderse para un debate en serio, no cejaremos en nuestros esfuerzos por abrir espacios de diálogo y privilegiadamente entregaremos a las autoridades de Gobierno y del Congreso, un completo informe con las propuestas, análisis y estudios que desde hace años ha venido elaborando el Colegio Médico.

Iniciaremos el 2003 recogiendo las renuncias voluntarias a sus cargos que los colegas han querido poner a disposición de la Orden, en una difícil y dolorosa decisión para los médicos de este país, históricamente comprometidos con el servicio público.

Dispuestos siempre a dialogar y participar en una Reforma de Salud en beneficio de la gente, reiteramos algunos de los principales aspectos de nuestra propuesta:

I.- **Plan Integral de Salud.**

Chile necesita un Plan integral de salud, con garantías no explícitas, explícitas, amplias y crecientes de oportunidad y calidad de atención, de acuerdo a objetivos y prioridades sanitarias. No un plan estrecho de prestaciones (AUGE) copiado de un modelo de "salud administrada" que ha sido un fracaso en los países donde se ha aplicado.

II.- **Prestaciones a Costo Real**

La Reforma tiene que partir solucionando la deuda hospitalaria. El pago de prestaciones a costo real exclusivamente para las patologías AUGE implica perpetuar esta sobrecarga e hipotecar las posibilidades de desarrollo tecnológico y de recursos humanos. Por cierto, significará postergar y rechazar a los enfermos No-Auge.

Proponemos el pago de todas las prestaciones a costo real. Esto significa la dictación vía de aumento significativa y gradualmente el aporte fiscal a salud, para alcanzar a un 3,5 % del PIB en cuatro años con un crecimiento anual de 0,6%.

III.- **Atención Primaria**

Los proyectos no abordan la baja resolutividad de la atención primaria de salud ni la integración de los diferentes niveles de atención, ya que el AUGE se centra en el nivel terciario.

Para dar una atención integral de salud, proponemos consultorios con no más de 20 mil habitantes, aumentar el financiamiento per cápita y estrechar su vinculación con la red hospitalaria.

IV.- **Reforma Pública de Atención**

La red del Sistema Público de Atención integrada por sus establecimientos debe tener con el sector privado una relación de complementariedad y no de competencia ni de fusión. Todos los hospitales deben acceder por igual a incentivos económicos y disponer de herramientas de gestión para el manejo más eficiente de los recursos públicos.

Asimismo, proponemos concursos públicos para los cargos directivos de hospitales y Servicios de Salud, terminando con el cuoteo político.

V.- **Regulación de Isapres**

Proponemos que se regule el poder de las Isapres, poniendo fin a las exclusiones y pre-existencias para todas las enfermedades, así como a las facultades unilaterales de alteración, revisión de contratos y reajuste de precios de planes. Para los médicos y los usuarios, es esencial impedir las malas carreras de prestaciones y la integración vertical (cuoteo clínicas), resguardando la libertad de elección de los pacientes.

VI.- **Derechos y Deberes**

Proponemos restituir la garantía de acceso a la salud –no sólo para el AUGE– y la atención preferencial de los discapacitados.

Proponemos la creación de un organismo autónomo que resuelva las controversias derivadas de la relación médico-paciente en una instancia de arbitraje y mediación, para evitar la judicialización de la práctica médica.

Además, deben garantizarse los derechos y deberes de los profesionales de la salud.

¡COMPROMETIDOS EN LA DEFENSA DE LA SALUD DE NUESTRO PAIS, INICIAREMOS EL NUEVO AÑO AUN MAS UNIDOS EN LA ACCION POR UNA REFORMA DE VERDAD¡

Colegio Médico de Chile

Source: Published in Newspaper *El Mercurio*, 29 December 2002

The *Colegio Medico* succeed in getting their message against the reformer coalition heard, but was not very effective for gaining allies as their campaign was seen as confrontational and negative by the public.

> *"I was mandated by the Minister for two years, to organise roundtables with the Colegio Medico, to open a dialogue as a political effort. …They played two games, they did participate in the roundtables and they won some things… but in parallel, they had a*

*parallel strategy showing themselves as enemies who did not believe in the reform...In the end, they did not change and their public discourse was that the AUGE was bad" (**Inostroza 2013**).*

As Minister Artaza explained, health workers unions were more favourable to giving their conditional support on improvements to the salaries and working conditions of their organisations. He commented that,

*"The behaviour of the CM was different from other unions because they resisted until the end. While the rest of the unions, around September, October, got what they wanted, which was to increase their salaries. And this implied an effort in negotiation with unions and other medical professionals: Fenats, Confenats, Confusam, and all of them achieved better working conditions. And therefore, the resistance of the unions was less ideological and more opportunist, so to speak" **(Artaza 2014)**.*

These differing goals between the *Colegio Medico* and the groups of unions of health workers might have been stimulated as a tactic developed by reformers, to divide the power of the radical coalitions and diminish the number of opponents. Ottone commented that political struggles with radical members favoured the perception of the reformer coalition,

*"We created a public debate in which we won more and more, in which we made a definition: for us, our goal, was not to improve working conditions of health sector employees… for us, they were not our target, our problem was about patients. Being a reformist has to do with helping patients and not to deal with health workers, even when they asked us: what about the dignity of the health workers? And we replied, what about the dignity of the patients? The dignity of the woman that goes to the doctor and the waiting lists? And little by little this idea gained more support…When this fight was debilitated? When there was a strike in an emergency hospital (La Posta) and President Lagos said "As you are not working in the morning I hope your are not working in the afternoon as well" [he referred to those who worked the rest of the day on the private sector] and that made a change, they realised the reform was definitely going ahead" **(Ottone 2013).***

In the case of moderate groups, the target of their actions was the mobilisation of the elite. The main strategy employed by Boeninger and Foxley was to make public statements via interviews or notes in newspapers. They also presented their views in internal DC party meetings as well with governmental authorities when their main concern, the funding plan presented by the reformers, was discussed. This was the case, for instance, of the insertion published in the dominical edition of *La Tercera (03 May 2002),* as well as a number of individual interviews in other publications in which they voiced their opinions. It seems that they exploited their capacity to determine the course of the reform based on their reputation as former ministers[36] and well-known politicians.

The neoliberal coalition also based their strategies on the dissemination of their views via press articles showing data supporting their discourse. They emphasised the deficiencies of the public system and looked at the implications of the reform for the private sector. Another activity suggested by some respondents was the utilisation of economic resources and networks with the entrepreneurial Chilean elite. These elites were involved, not just in the health sector, but also in alcohol, tobacco, and mining companies, which were supposed to be affected by the tax increase proposed by reformers. As implied by the answers of people outside this coalition, this type of relationship had a negative connotation. For instance, Esteban Maturana from the radical coalition explained,

> *"Obviously, the ISAPRES were in tune with the world of the right, they have a closed relationship, very supportive… it was an open secret that the congress representatives from the right had systematic and permanent coordination with the ISAPRES, and that allowed them to have very clear ideas* ***(Maturana 2014).***

Furthermore, the executive secretary of the reform, Hernan Sandoval explained the link between ISAPRES and right-wing parties, emphasising the specific role played by Andres Tagle,

[36] Edgardo Boeninger was appointed by President Patricio Aylwin (1990-1994) as Minister of the Presidency, and Alejandro Foxley as Minister of Finance in the same period.

"Very strong, they were always present. The one who acted as a representative of the ISAPRES in the parliamentarian committees was Mr. Tagle, who at the same time was a member of the UDI and a representative of the Association of ISAPRES…. He was the one who lobbied and gave instructions to the parliamentarians as to how they should vote in the Chamber of Deputies and in the Senate" ***(Sandoval 2013).***

However, these mechanisms of influence are more difficult to trace, as for instance, lobbying is not a regulated activity in Chile and therefore no records can be found of lobbyist activities. Financial connections between entrepreneurship and legislators are also difficult to find, though some cases demonstrate linkages that are more evident. For instance, an article from La Tercera established the connections of Andres Tagle,

"One of the visible faces defending the ISAPRE was the engineer Andres Tagle, vice president of Association of ISAPRES who was part, until last week, of the political commission of the UDI, and was the electoral expert of the 'gremialismo'[37] *in the municipal elections from 1992 onwards. Tagle played a crucial role in the Joaquin Lavin*[38] *campaign…but Tagle was not the only guy that made things complicated for the UDI. One of the members of Lavin's crew is the entrepreneur Carlos Alberto Delano. The owner of the holding PENTA was an advisor of Lavin when he was a Major of Santiago and he was part of the 'samurais' [a nickname for their groups of friends]. Currently he is part of the board of the ISAPRES Banmedica and VIDA TRES"* ***(La Tercera, 13 July 2002).***

It is also worth noting that when I interviewed Andres Tagle, he emphasised that his participation in the reform discussion was on behalf of ISAPRES, but did not mention his political affiliation to the UDI party. In the case of the representatives of ISAPRES, they were also very cautious during the conversation to avoid connections with the right-wing parties.

[37] People affiliated to the UDI political party are also called "gremialistas" as some of its old members were of the "movimiento gremial" which was a group founded by Jaime Guzman created in the sixties formed by students within the Universidad Catolica de Chile. Guzman was the lawyer mandated by Pinochet to define the legal-political framework that resulted in the Constitution of 1980. See more about 'Gremialismo' in Huneeus (2000).

[38] Joaquin Lavin was the presidential candidate from the UDI party who ran against Ricardo Lagos in 1999.

Regarding strategies of this sector, the initiative "The Pro-growth Agenda" (*Agenda Pro-Crecimiento)* was published in a number of press articles but scarcely mentioned in the interviews. It was pushed by the government and two institutions comprised of the wealthiest entrepreneurs in Chile: the Federation of Chilean Industry (*Sociedad of Fomento Fabril-SOFOFA*) and the Confederation for Production and Commerce (*Confederacion de Produccion y Comercio-CPC*). This initiative took place at the same time that the health reform was being discussed, with the aim of designing a set of joint actions to improve the business development framework and the national economic environment. A press note from ***El Mercurio (10 May 2002)*** mentioned that the CPC began a round of talks with political party leaders before the presidential message of 2002. In this matter, an advisor from La Moneda discloses,

> *"I remembered one day in the SOFOFA with Juan Claro [the President of the business organisation], when the board of the entrepreneurs were changing their opinions, from ones less committed to Pinochet and more committed with the country…they told us that the ISAPRES would not be an impenetrable wall [and they would be open to negotiate]"* ***(Ottone 2013).***

Thus, it might be plausible that this particular context, the collaboration between the government and the business sector, affected the way that the discussion of the health reform was framed, making previous adversaries adopt a more flexible approach to negotiate issues like the transference of funds or the regulation of the private companies in this area.

Indeed, changes in the ISAPRES system were given priority by the Lagos administration and they introduced two initiatives to regulate private sector businesses. The first one, Law Nº19.895 (informally called "the short-law of ISAPRES") was focused on the establishment of financial stability procedures for private companies, in order to protect affiliates from bankruptcies. The second initiative was the Law Nº20.015 (the "Long Law of ISAPRES") which sought to improve all aspects, regarding ISAPRES' transparency in contracts and premiums, not included in the first bill, seeking to eliminate discrimination by gender and age in private insurance plans.

At the time these laws were submitted to the Congress, a particular event determined the outcome of these initiatives'. As some interviewees mentioned, "the short law" quickly materialised due to an internal crisis in one of the conglomerates that managed private health services (ISAPRE Vida Plena) and pensions funds, called Inverlink. At the beginning of 2003, this company was

involved in a financial crisis and went bankrupt, causing economic loss for hundred of affiliates. This particular event favoured the reformer' plans, as a set of norms to ensure the solvency of private insurances companies and to oblige them to disclose their financial status to their affiliates that were included in the health reform package. The lead advisor for the Ministry of Finance recalled,

> *"We had the Monsterio's crisis –Inverlink– and we had to write a specific project about what we should do if an ISAPRE or an insurance company was at risk of bankruptcy, what was going to happen with the affiliates and other suggestions to increase the regulation of ISAPRES. We had to do this very quickly because we did not know how long this opportunity would last"* ***(Tokman 2013).***

As both initiatives were focused on increasing the rules and norms for ISAPRES, members of the neoliberal coalition would be keener to defend their interests. Nonetheless, given that the INVERLINK crisis explicitly revealed the deficiencies and risks associated with the unregulated business of ISAPRES, former neoliberal representatives at the Senate cooperated in legislative debate. They took a pragmatic attitude towards the bill as the former minister of Health, Pedro Garcia, mentioned,

> *"When the INVERLINK issue happened, it was useful for me because I could honestly talk with the right-wing parties…it was an evident scandal, we were not inventing anything…The vertical integration, the transfer of funds from a financial holding to ISAPRES, to private clinics that belong to the same holding… We stated that they [the financial holdings] can exist, but they must have the monies separate. That event helped us a lot in the discussion"* ***(Garcia 2013).***

7.3 USING TECHNICAL KNOWLEDGE TO BUILD CONSENSUS

Data from the interviews suggest that each of the four coalitions had their own team of advisors, who provided expertise and technical knowledge during the first phase. Most of the initial design of the reform proposal took place within the government, where the reformer coalition had a forum of specialists working within the government. People that participated as an advisors of this

coalition explaining that while during the first two new democratic governments, *the Ministry of Health* received external funds from the World Bank to developed the basis for a plan to reform the health sector, based on the principles of cost containment and efficiency reducing the role of the state; during the period of Lagos' due to the political and economic stability reached by the country, credits and loans were substantially reduced, by still the ideas of some international organisations as the Bank and the World Health Organisation were circulated within the governmental team. The first Minister of Health after de dictatorship, Jorge Jimenez explained that at the time,

> *"There was a huge investment of external resources to improve the public infraestracture. There were loans from the World Bank and the Interamerican Development Bank, and collaboration from other governments who supported the internal democratic forces against the dictatorship in Chile…there was an internationalisation of the Chilean health policies as it was one of the first countries to think in a major reform…but there was no political will to do it. Instead, several principles that appeared in the World Health Report of 2000 such as the promotion of health, justice and equity were present in our reform"* ***(Jimenez 2013).***

The inspiration of these ideas were adopted and put in place by the governmental team, as Andres Romero recalled,

"Until Artaza came, the committee appointed by President Lagos, led by Hernan Sandoval, was the group that technically worked on the project, or the idea rather than the project…this committee worked well apart from the ministry in a very controversial context, but when Artaza took office, we brought the reform to the Ministry" ***(Romero 2013)****.*

The Ministry of Health hired Andres Romero when Artaza took office in January 2002 to write the legal framework of the reform. He remained an advisor of the Ministry until the bill was approved by the Senate in 2004. He and other advisors were part of a large decision-making structure organised by the Presidency: i.e. The Inter-ministerial Committee, where public policies were coordinated among the different governmental institutions. However, the technical aspects and particularities of the project were developed within a small group of advisors that made decisions on behalf of their own ministers. Romero explained their role as an advisory team for the inter-ministerial committee,

"This committee of ministers was translated into a technical committee, and we had the same work plan, so to speak. For instance, Tokman was the person from the Ministry of Finance, representing the Ministry of the Presidency (SEGPRES) was Carlos Carmona and his lawyer Ulises Nancuante[39] *and I was there as a representative of the Ministry of Health. Then, if we could not get an agreement about an issue, that issue was passed to the Minister's committee and if they did not agree, they passed the problem to the President. So, there was always an incentive to not pass the issue to the committee ministers. Also the ministers tried not to pass the problems to the President. I recall just two occasions in which we brought the problem to the President, very few. The rest of the issues were negotiated, of course. I had to check everything with my minister, Tokman with Finance… and it was an interesting formula to work with the rest of the ministries"* ***(Romero 2013).***

In order to produce a proposal that produced consensus about the financial issues of the reform, technical members from the Minister of Finance collaborated with specific parliamentarians from the DC to settle the various opinions ***(La Tercera, 06 June 2002).*** The representative of the Ministry of Finances, Marcelo Tokman illustrated this collaboration,

"When the bill was in Sentate, I had to, on behalf of the government, to negotiate the details of the project with people from the DC …I was accompanied by Consuelo (Espinoza)…sometimes with Manuel Inostroza from the DC, and Hector Sanchez, and we made several changes to pass the bill in the Senate quickly" ***(Tokman 2013).***

Radical members had people close to the Socialist Party that were working with Bachelet, as advisors, in the first two years. Minister Artaza mentioned in particular the name of Soledad Barria,

"This is very comical, because I told you about the advisors of Bancada Medica. One of the main advisor was Soledad Barria, who years later was appointed as the Minister of Health –during the first period of Bachelet– and she had to implement the AUGE. You

[39] Andres Romero and Ulises Nancuante published a book with the legal details of the reform. Romero, A. y U. Nancuante. 2008. *La Reforma a la salud.* Editorial Instituto Salud y Futuro: Universidad Andres Bello.

never know where life will take you…because she was a brutal opponent to the AUGE, and then she was the Minister responsible for its implementation" ***(Artaza 2014).***

In the case of the neoliberal coalition, the think tanks were relevant actors as they provided technical data to the legislators from the UDI and RN. The advisor from Fundacion, Jaime Guzman, explained that they had an internal team to work in this reform,

"In Libertad y Desarrollo, we had our own advisors and a small team where we discussed the issues of the reform, with people that were working in hospitals and those that had experiences in public health" ***(Figari 2014).***

After the bill was passed to the Senate, in order to craft a passable proposal, reformers drove the integration of the experts from the moderate and neoliberal coalitions with the team from the executive branch. Furthermore, the technical knowledge required at this point was supplied by a diverse group of advisors from the Ministry of Health and Finance, as well as from right and centre-left think tanks.

Hector Sanchez, Director of *Salud y Futuro*, a think tank close to the DC, told me that he was asked by Edgardo Boeninger to gather these crosscutting actors into a group that advocated political parties to endorse the bill. He had previous experiences working in the public sector as advisors of the Ministry of Health during the Aylwin and Frei Administrations and he then occupied a position in the private sector. He became the director of a private medical centre, Integramedica, and simultaneously, the director of *Salud y Futuro*, which was a think tank based in a private university in Santiago. He explained that this combination of experiences in both the public and private sectors helped him to manage the process in Congress,

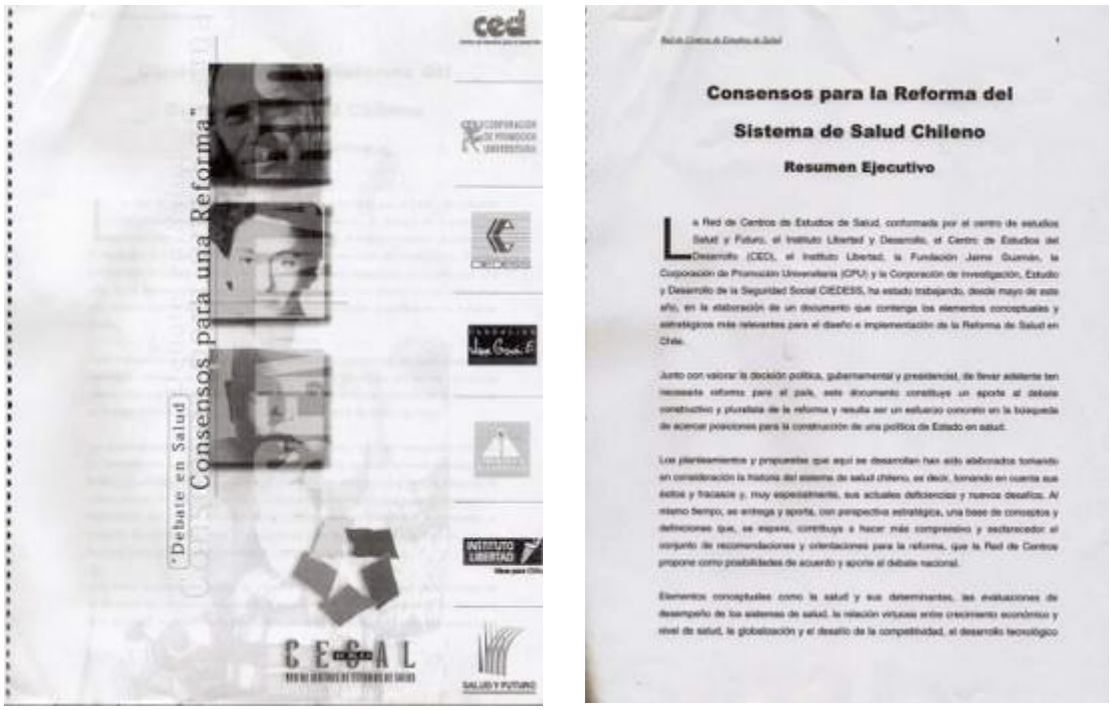
"I conducted different types of research, organised seminars and roundtables in which I invited leaders from different sides and political colours, and we circulated the different proposals. We perpetually appeared in mass media, radios, TV, newspapers…and some of these proposals were included by the commission…I organised roundtables with everyone from the political world and with entrepreneurs. I learned as a businessperson that they [entrepreneurs] can ruin everything, so I started to meet all of the ones from the private insurances companies" ***(Sanchez 2014).***

This became a small but very influential network called the Health Studies Centres Network (*Red de Centros de Estudios de Salud*-CESAL), which was composed of *Salud y Futuro, Instituto Libertad* (IL), *Centro de Estudios del Desarrollo* (CED), *Fundacion Jaime Guzman* (FJG) and the *Corporacion de Promocion Universitaria (CPU)*. Hector Sanchez mentioned,

> *"Most of the conceptual content, proposals and guidelines of the reform were elaborate by this group. As opposed to the notion that everything was made inside the executive committee headed by Sandoval and his team"* ***(Sanchez 2014).***

The next illustration shows the cover and first page of a document created by CESAL, which was signed by all the think tanks mentioned:

Figure 5: Document "Consensus for the Chilean Health system Reform" by CESAL



Despite this document reflecting that think tanks were coordinated by CESAL, most of the people interviewed did not come across this network. They recognised the individual roles of people from CESAL, for instance, Hector Sanchez was one of the convenors of this event, but there

was no mention of formal agreements emanated from this group. Those who participated in the reform debate as advisors, told me that the group who played the most important role was not the whole network of think tanks, but a group of 5 or 6 people. This group worked with the parliamentarians Matthei and Boeninger and the Minister Pedro Garcia. Nicolas Figari from Fundacion Jaime Guzman asserted,

> *"It was a group that worked without interruption during those years, Andres Romero, Marcelo Tokman, Consuelo Espinoza… In spite of the guidelines that came from the government, the proposal was addressed as a state issue during the legislative process. It was discussed on a technical basis but also with the political will to create a consensus that this reform would make significant changes to the health system. So, consensus was needed and I think the Lagos government was clever to understand that"* ***(Figari 2014).***

A quote from the interview with Esteban Maturana captures the sense of collaboration by actors who were previously antagonists,

> *"In fact, during the reform discussion, Ricardo Lagos' ideas were supported by the right wing think tanks, such as Libertad y Desarrollo and Instituto Libertad…People ideologically neoliberal from right wing think tanks"* ***(Maturana 2014).***

As perceived by the interviewees, in order to pass the bill, there was a serious and meticulous process of work developed by this group. The result was that technical information and expertise provided support to the political will of legislators in the Senate health committee.

Considering that the DC had internal factions that systematically opposed the reform, the role of the technical group within this party in this process is interesting. This is particularly the case as, in the end, they became a key part of the negotiations in both political and technical spectrum. The narrative of the DC emphasised that this party had more expertise in the health sector, than that that was developed through ten years of leading the Ministry of Health in the post-Pinochet period. A former Minister of Health in the Aylwin administration commented,

> *"We have more knowledge, expertise, we had technical groups, and we had the support of the establishment within the public sector. In the socialist party, there were no public figures in the health sector. There were some communists, but they were outside…the PDC was, during the first 20 years of the Concertación the 50%… before, the DC had*

more votes than all the other parties of the Concertación. Besides that, the two first presidents were DC. It was a privilege, I had to lead the health commission during the previous years before the plebiscite, and after that, I was minister, and all the other ministers until Bachelet, were DC. After Bachelet there was Artaza and Garcia and so on" ***(Jimenez 2013).***

"Historically the DC had led the health sector, the majority of health ministers had been from the DC. The DC had a strong technical team in health... The DC took a relevant role in this, they organised a team that accompanied the whole process from a very political standpoint" ***(Romero 2013).***

Despite the fact that the strongest factions within the DC party blocked the reform proposal until the Senate stage, they had an accumulated experience in the health sector that was a valuable source of knowledge for the design of public policies. This expertise, information, and knowledge, helps to explain the capacity of some party members to manipulate the debate. It was after Bachelet that the government again appointed DC militants as health ministers, Doctors Osvaldo Artaza and Pedro Garcia. While Artaza went through a highly conflictive period with three opponent coalitions (and not always with the support from the party leaders), the interviewees suggested that it was Pedro Garcia (largely due to his personality) who played an important role in promoting consensus. Furthermore, in his role as a member of the DC health team, he had already been working on preparing alternatives to the government proposal. The vice president of ISAPRES in that period, Andres Tagle, commented on Garcia's position,

"When the last minister [of the Lagos administration] arrived, he was the one who pushed the reform forward, and it was with him that things really started to move. There was a union, I would say, between Sandoval with the La Moneda [Presidential Palace] team…about the real reform they wanted and from then, they moved ahead. It was very straightforward" ***(Tagle 2013).***

In addition to nominating a DC as the Health Minister, the inclusion of other militants on the technical team was also a tactical move to bring about consensus within the party, ensuring compliance with the health commission. Sanchez realised that the party needed to sort out internal problems before building support in Congress,

"We learned that we needed to negotiate this project at home and then sell it outside. Then, we began to operate within the DC, and we took control of the internal committee of health within the DC, Manuel (Inostroza) and I, and when we took control of the board members of the party, we got the political support to negotiate with the government" ***(Sanchez 2014).***

As the internal conflicts within the DC were managed, the collaboration of technical experts was the essence of the negotiations in Senate. As the advisor of the *Fundacion Jaime Guzman* explained,

"In spite of the number of the interest groups, and I want to be honest in this, in general we made decisions based on consensus…But in the end, we did very professional work, making the best decisions based on technical data" ***(Figari 2014).***

7.4 POLICY BROKERS

Sabatier and Jenkins-Smith (2007) suggest that the struggles between coalitions can be mediated by specific persons that assumed the role of policy brokers, with the aim of reducing the polarisation between the groups involved. This mechanism of influence was used by the dominant pragmatic coalition at the Senate. In this scenario, reformers had the ability to transform themselves into a coalition composed of people from different political parties, enabling the bill to pass in Congress. In spite of their different viewpoints, policy brokers became relevant actors, defending a common goal, instead of fighting about individual preferences. An interviewee stated that a process of negotiation required people capable of bringing about specific conditions,

"You have to have agents able to articulate, that allows you to create agreements between actors, and in this point, it is crucial to mend fences, to create trust" ***(Sanchez 2014).***

Although during the reform debate in the Senate different actors from rival coalitions, such as Colegio Medico and ISAPRES, were invited to the public sessions of the health committee, these did not fundamentally change the bill that was being discussed in Congress. Furthermore, the draft bill mainly reflected the views from members of the pragmatic coalition supported by a

crosscutting technical team. An advisor from the Ministry of Health observed that in comparison with the first phase, the Senate was a less polarised context to negotiate in,

> *"The Lower Chamber was more conflictive, the most difficult to convince…with the senators I mentioned: Boeninger, Viera Gallo y Mathei, Espina, we achieved an agreement, and then we could impose political discipline on the rest of Congress"* ***(Inostroza 2013).***

With the leadership of two specific actors: Evelyn Matthei and Edgardo Boeninger from the neoliberal and moderate coalitions, the pragmatic coalition succeeded in controlling the reform agenda and consolidating a block to support the bill. Sebastian Soto confirmed this, saying that:

> *"The leadership of some politicians was very relevant to moving forward and getting an agreement over the agenda. I am thinking especially of Matthei and Boeninger"* ***(Soto 2014).***

As former Minister Garcia noted, despite the policy process being smoother in the Senate due to the consensus within the sectorial committee members, he still had to manage struggles within the health committee,

> *"I was lucky, I had to negotiate the bill in the Senate after the first legislative step with the committee members, for instance, Alberto Espina, who had a good understanding, and Evelyn Matthei who understood a lot more than anyone else. She was the leader of the opposition at that time. And there were other senators from the Concertación, Viera Gallo and Ruiz Esquide. And Ruiz Esquide was the only DC, who was supposed to be closer to me, but he was very conservative in the way, he saw health issues and was very difficult to manage"* ***(Garcia 2013).***

The strategy employed by the reformer coalition was to approach Senator Boeninger, who was less extreme than Ruiz Esquide, as a way of taking control of the DC's internal factions and managing the opposition within the *Concertación* parties. The legal advisor of the Ministry of Health and a DC militant said,

> *"The President knew what was going on, and that the negotiation had to do with the DC, and Edgardo Boeninger was a key actor to the effect of getting an agreement and he took*

this role as mediator very seriously, and a specific team was built for this" ***(Romero 2013).***

The narrative of the respondents confirms that Edgardo Boeninger was a "*primus inter pares*" in the Senate, one who organised the discussion and negotiation of the reform at Congress in agreement with La Moneda. This was reflected in the opinion of Sebastian Soto, from the think tank Libertad y Desarrollo,

"He was unique, unique in the sense that he was the voice of the Concertación, and the one who made the most important decisions, and he was present in every detail" ***(Soto 2014).***

Pedro Garcia mentioned that when he was appointed as minister, President Lagos said to him,

"If you have any questions, talk to Boeninger…He was indeed the person there, he was the man in Congress and in the health committee" ***(Garcia 2013).***

The lawyer for the ministry and part of the technical team in the Senate describes one situation that illustrates the skilful guidance of the Senator. It was during a discussion about creating one or two different bodies to supervise the function of insurance institutions,

"For socialist legislators, it was impossible to accept that FONASA was classified as health insurance, it was unacceptable, as for them, it was a solidarity fund. They wanted to reject the creation of Superintendencia of Insurances because of the name. In that moment, Boeninger was very clever and he said: 'what about if we add [to the Superintendencia] Provisional Insurance Funds to the name?' And it was approved but it was silly, because there was just one fund! It was finally called Superintendencia of Funds and Provisional Insurances of Health" ***(Romero 2013).***

Along with the identification of Boeninger as a helpful and skilful member of the pragmatic coalition, Senator Evelyn Matthei also emerged as a relevant part of the policy process. Former Minister Pedro Garcia explains,

"I can tell you, Evelyn Matthei was the woman. I appreciated her, because she was reckless and sometimes rude, but she was a very serious woman. If you could explain to

her that something was wrong, she understood because she had experience, and because she did not like foolery" ***(Garcia 2013).***

The advisors from the think tanks close to the right wing parties shared this sentiment,

*"Evelyn Matthei, the senator, was powerful, with argumentative capacity, very intense, with a strong character and presence. She assumed leadership very quickly…"****(Soto 2014).***

Nicolas Figari described the Senator as follows:

"She was smart, intelligent. She was very incisive with the government, she asked questions and then the government had to call for a meeting to see how they would reply to her. It happened several times that she left them with no answers…Her focus was on technical and economic issues…She brought empirical examples to challenge the applicability of the reform" ***(Figari 2014).***

What respondents implicitly insinuated is that Evelyn Matthei became a key person in this process for two reasons: First, she had a degree in economics; and second, because she had German ancestors, for which she earned a reputation as a very serious and meticulous person, giving her "enough credentials" to be part of that debate. These characteristics (factors that were not mentioned in the case of Senator Boeninger who also studied economics and had German ancestors) made her to be perceived as an independent-reasoning person that was not influenced by pressure from interest groups like ISAPRES. It is worthwhile explaining some features of Evelyn Matthei's political career to put these findings into context. She was the daughter of Fernando Matthei, a member of Pinochet's Military Junta as Air Force Commander, where she was responsible for the Ministry of Health from 1976-1978. She was also served as the Minister of Labour in President Pinera's Administration (2010-2014). When she left the Cabinet, and after two other candidates from the right-wing alliance abandoned their presidential campaigns in 2013 for personal issues[40] she ran for president against Michelle Bachelet. Matthei did not have the backing

[40] One was involved in money laundry and the other quit because he was suffering depression.

of all the right-wing political parties, and she was running a campaign with little expectations. After she lost in December of that year, she retired from politics.

Getting back to her role in the health reform process, when I asked Sebastian Soto, from *Libertad y Desarrollo*, if there was any communication between the Senator and the private insurance companies during the negotiation, he responded that,

> *"I do not think that Evelyn called them and asked them what they thought about the article number 26, I think there was a way to go, and that way was very clear and we needed to go ahead, defending and negotiating this [the reform approval]"* ***(Soto 2014).***

The advisor to the Finance Minister also commented that there was no clear link between ISAPRES and the work of Evelyn Matthei in the Senate,

> *"I do not think so, it was not that absurd, I would say she defended the ISAPRES from an ideological point of view, she defended their existence. But she was also critical of some aspects, except with the solidarity fund, but she agreed in general with one compulsory plan to ISAPRES and Fonasa"* ***(Espinoza 2014).***

Despite the comments about the sources of her capabilities, a quote from the interview with former Minister Garcia gives a sense of her power,

> *"Eyzaguirre and Tokman -authorities from the Ministry of Treasure- had very good relationships with a number of parliamentarians, a very good relationship with Evelyn Matthei. Evelyn Matthei trusted in both. And if they, Eyzaguirre and Tokman, validated me, Evelyn Matthei validated me…She was the one who made decisions in the Senate"* ***(Garcia 2013)***

Even though the Senate was less conflictive than the discussion carried out Chamber of Deputies, the pragmatic coalition still faced obstacles and challenges in passing the bill in the second phase of the policy process. In the end they had to make concessions about important elements, the initial funding scheme and the solidarity compensatory fund, from the original reform project to achieve an agreement. Pedro Garcia described the rejection of the right-wing parties to the Solidarity Compensatory Fund and how it was managed by President Lagos' team,

"And Matthei said to me 'Look Minister: we like all this idea [of the reform]… but if you do not take out the Compensatory Fund, we are going to vote against the idea to legislate the AUGE'. And if they rejected the bill, that meant we failed…There were people from the left who also thought this Fund was negative for FONASA, supporting the argument of the right …I explained this to the President, and he said that although they were blackmailing us, we must take this policy out from the bill" ***(Garcia 2013).***

Once the disputes that concerned Matthei and Boeninger were sorted out via transaction, both legislators were keen to pass the bill and to align their political parties to vote through the health reform in the Senate. A member of the pragmatic coalition explained,

"We were able to get this reform through by giving away the things that we needed to. And we got what we got. Like Obama, he wanted an ambitious reform, but he got what he could…At least we got the AUGE, which was the most important thing for the FONASA people, and we made a partial reform to the ISAPRES system. But we could not make it with the lack of solidarity and the transfer of risks, which were the final goals of the reform" ***(Inostroza 2013).***

This quote captures the sense that, at this stage, coalition members adopted strategic negotiation, where they made concessions in order to achieve a partial but still a substantive reform of the health sector.

Table 12 Distribution of political parties in the Health Committee at the Senate

2 PDC	1 PS	2 RN	1 UDI -Independent
Mariano Ruiz Esquide (Doctor)	Jose Antonio Viera Gallo	Alberto Espina	Evelyn Matthei
Edgardo Boeninger		Mario Rios*	

Source: www.senado.cl

*Senator Rios was replaced by Senator Espina

Table 13 Distribution of political parties in the Finance Committee at the Senate

2 PDC	1 PS	1 RN	1 UDI -Independent
Jorge Lavandero	Jose Antonio Viera Gallo	Pedro Garcia Ruminot	Evelyn Matthei
Edgardo Boeninger			

Source: www.senado.cl

7.5 SUMMARY

The aim of this chapter was to show the different resources employed by the four coalitions in the process of formulation and discussion at the Lower Chamber. Acknowledging the different contexts in the first and second phases, I show the different resources employed by the four coalitions in the process of formulation and discussion at the Lower Chamber. These strategies changed with the context in the legislative debate in the Senate. The evolution of coalitions explained in Chapter 6 and this chapter reflected on how the strategies of the coalitions evolved as well. They were public and confrontational at the beginning, and less polarised when the pragmatic coalition replaced the four initial coalitions.

Despite the factionalism and opposition from the three coalitions (neoliberal, moderate, and radical) against the reformers plan, the reformers managed to mobilise the resource and employed strategies that pushed the reform through the different stages of the policy process. As there was a dynamic evolution of coalitions, the type of strategies used by the actors also varied. These strategies had different outcomes and changed when the bill passed to the Senate. In this second phase, there was a process of consensus building based on the assistance of an advisory team, which provided technical knowledge to coalition members. In addition, the role of the policy brokers and their skilful leadership was crucial to brokering a negotiated settlement within the pragmatic coalition.

The next chapter will examine the findings from interviews and congressional hearings regarding the implications of institutional arrangements in shaping the coalitions' interaction through the two phases of the health reform process.

CHAPTER 8 THE IMPACT OF THE INSTITUTIONAL STRUCTURES ON THE HEALTH SECTOR REFORM

8.1 INTRODUCTION

After arguing in chapter 7 about that the mobilisation of resources, the contribution of a group of advisor and technocrats, and the role of policy brokers facilitated the achievement of agreements, the present chapter tackles the implication of institutional arrangements of the Chilean political system, by reviewing the interviews to relevant actors and congressional hearings from the health reform process.

The focus of this chapter is to further analyse in to what extent these factors enabled or constrained the policy shifts on the health sector. From the analysis of data, three main institutional structures are assessed for their impact on the health reform: two legacies directly derived from the Constitution, as formal arrangements within the political system; and the third one resulting from the introduction of market-based reforms in social policies. The findings of this study show that political participation in the health sector, the presidential powers and the electoral system became relevant factors in the policy process. Therefore, I examine how coalitions coped with them.

8.2 POLITICAL PARTICIPATION AND CONTESTATION WITHIN THE HEALTH SECTOR

As explained in Chapter 4 and confirmed by my interviews, the re-organisation of the health system during the dictatorship created new actors and new rules for the game, imposing market mechanisms in this sector. Two particular features that had implications for the health reform processes emerged from the structural transformation. First, there was the creation of an economic elite in the health sector industry, composed of owners of private insurances companies, private practices, and clinics. Second, following the logic of the military authorities regarding civil society demobilisation and de-politicisation, citizens became outsiders of the policy process as participation was severely banned. Although the democratisation process was supposed to bring back a balance into political participation, the evidence shows that influence of the coalitions identified stuck to the distribution of power that arose during the years of the dictatorship.

In terms of opportunities for participation, according to the data, some activities were specially organised for civil society groups. The first such activity was led by Minister Bachelet and took place in January 2001, attempting to integrate several social actors in the discussion of the national health goals for the decade by extending invitations to community leaders across the country. These meetings were described in different data sources,

> *"More than four thousand social leaders with community representatives were invited to join the discussion on the reform, in 50 participation days since January 11, in Concepcion, Santiago and Porvenir, to determine regional issues and to define the goals for the decade"* ***(El Mercurio, 06 January 2001).***

> *"There were meetings organised by the Ministry of Health, directors of health institutions were asked to organise meetings with communal actors. And we, as authorities from the Ministry, went to support these regional meetings…in which there were presentations and participative discussions…there were more than 2,000 meetings with neighbourhood-based organisations…they participated actively"* ***(Herrera 2014).***

A quote from Minister Bachelet in a newspaper illustrated the character of those meetings,

> *"We do not want a reform made on the back of the Chileans…the health reform should be a participative process, in which users and citizens play a significant role. We believe that it is quite important that the decisions we make are based on peoples' orientations, as we think the focus of the reform is precisely the people"* ***(La Nacion, 06 January 2001).***

Additional activities to integrate citizens and unions were organised in August of the same year, in which various working groups discussed the scope and content of the reform. There were four groups comprised of all the actors involved in the health sector: ISAPRES representatives, health workers unions, medical associations, users from both private and public services, civil society, and community leaders. The opinion of one of the participants illustrates that the roundtables were important to the process,

> *"With Bachelet, there were working committees with representatives from the civil society, I mean, users, unions, from different organisations interested in health. For instance, there were organisations of people with rare diseases, political parties, organisations from primary care and parliamentarians, and people from the government.*

> *There were different activities to share and discuss the basic principles of the reform…Initially, there was a feeling that we could shape its content…but when we had to analyse critical points such as funding, private insurances and so on, the problems began. There were different opinions from ISAPRES, private clinics representatives, people from the private sector. But we also had problems with people within the Government…but overall, the roundtables were very important, they took place in different regions of the country, and they were very participative"* ***(Maturana 2014).***

As they did not see any progress during her administration in terms of the reform, some respondents viewed the consultation process as Bachelet's strategy to delay the process, blocking President Lagos' agenda. In fact, in legislative terms, there was just one project submitted to the Congress by Bachelet in June 2001, the law about the rights and duties of patients (Law Nº20.584). This project was the first to be sent and the last to be approved, in April 2012, more than ten years after the project was delivered to the Congress. Although, the informants and the press mentioned these regional meetings and roundtables, I could not find the specific names of those who participated in the meetings, which could be an indication of the lack of influence the community had in this process. Instead, some health workers organisations: nurses, paramedics, regional representatives, among others, were clearly identified in media sources.

A second initiative mentioned by the informants took place within Congress, where public audiences were organised by the permanent health commissions of the Chamber of Deputies and the Senate.[41] While the four coalitions had parliamentarian representatives, the transcriptions of these public audiences show that different groups of actors attended these sessions in first and second legislative stages. Although the initiatives were seen as a democratic channel of participation, the impact of the organisations formed by patients or users of health systems was limited. Given that they did not have formal access to the centres of decision-making and that there were no binding decisions from the activities in which they participated, it seems that these initiatives were focused on technical and expert knowledge from the government team, rather than the needs expressed by societal actors. Congressional hearings showed that the participants were

[41] See Appendix F, with the diagram of the law making process.

mainly health workers and private sector representatives. The exception to this is the discussion of the ISAPRES Law, where Pedro Barría, President of an organisation of affiliates and users of ISAPRES were invited (***Congressional Hearings Law No 20.015).*** In fact, during the discussion about the content of the Authority Law, a deputy from the *Bancada Medica* emphasised that the lack of participation needed to change,

> *"Another very important aspect of the project, which must be included, is the issue of citizen participation in management. It is not acceptable that, in the current situation, citizens do not have any participation in the knowledge of primary or hospital services. For that reason, we are going to present one suggestion about the participation of neighbourhood councils and social organisations in primary services, to get them involved in the management. We need to open channels of communication based on reciprocity with health sectors workers, and vice versa" (**Deputy Enrique Accorsi, Congressional Hearings No.19.937, 08 October 2002).***

Indeed, Lagos took steps to address some of the issues derived from the unbalanced situation in terms of citizen participation in public policy decisions. For instance, in his reform he included citizen participation in policy-making bodies known as Advisory Councils (*Consejos Asesores*) to develop sanitary policies and help in the management of public health centres. Additionally, citizens were given the prerogative to systematically evaluate public health services (Law No.19.937) and the capacity to demand the fulfilment of deadlines in the AUGE Plan (Law No.19.966). These were stated in the legal framework to create a more balanced relationship between citizens and health sector providers after the enactment of the laws. However, what became clear in the interviews is that the policy process was concentrated and managed by the Chilean political elite with access to formal power centres. As the former Health Minister said, this reform did not emerge from citizen involvement,

> *"The way it was approved – the reform – was curious, because in theory, it should have a degree of involvement from the citizenship in its design and implementation, and here, it was nothing like that. It was totally top down, and I would say it was because, at the moment, the country was not prepared to have a bottom-up reform" **(Artaza 2014).***

8.3 LAGOS AND HIS PRESIDENTIAL POWERS

One of the institutional arrangements highlighted in the interviews was the considerable advantage the executive was given over the legislative branch in the 1980 Constitution. As stated by articles 62-64 of the Constitution, the President has the legal initiative (a capacity to start the legislative process) on issues of political and administrative divisions, financial matters, and policies concerning the national budget and taxes.[42] The president's right of veto is one of these powers. The president can veto any legislation enacted by Congress, while allowing Congress to propose modifications to, but not dismiss, legislation presented by the President. Furthermore, respondents agreed with the idea that the presidential regime in Chile influenced the public policy process but did not provide details on how the President exercises this leverage over other institutions. In this respect, a neoliberal and radical coalition members commented,

> *"There is, yes, a presidentialism, in which some issues are initiatives of the Executive exclusively. The Congress cannot make, for instance, an ISAPRES law by itself or in the pensions sector, because the initiative comes exclusively from the President" (**Tagle 2013**).*

> *"He [the President] decides which issues are discussed and which are not…and the most important issues for the country, the ones that have to do with money, the legal initiative is decided by the President, and Congress does not have any capacity on these matters" **(Maturana 2014).***

In exploring this through a combination of data sources, what emerged was that President Lagos simultaneously exercised his presidential power through formal and informal means to ensure the approval of the reform within his administration. In this context, the reformer coalition counted on the prerogatives inherited by the President that favoured the introduction of the bill. In a formal exercise of this power, Ricardo Lagos submitted a health reform package that included a redistribution of public budget, increases in taxes, and the transfer of funds between the private

[42] See Chapter 2 about presidential prerogatives.

and public sector. This package also had policies related to the reassignment of the functions of regional authorities, and the creation of the *Superintendencia* of Health as a regulator body.

The Executive also defines the priorities for the discussion of the bills, and when setting up the deadlines, the President is able to define the legislative priorities and the timing of the discussion. The specific bills were sent to the Congress with a "simple urgency "(*urgencia simple*),[43] which means they had 30 days after their submission to analyse the proposals in both chambers. The only exception was Law Nº19.888 about funding for social programmes, which was sent with "summa urgency" (*suma urgencia*) and therefore, had to be analysed in 15 days. As the president could modify these urgencies freely, he could decide to change the agenda if the government realised that the bills were subject to controversy and could result in the delay or rejection of the initiatives. During the discussion of the Authority Law, Deputy Lorenzini stated,

> *"The legislative urgencies are not defined by us. We [the parliamentarians] are still waiting for a reform that gives us the possibility to define our rhythm of work. Currently, the President defines urgencies and we work according to that. For that reason, the Chamber of Deputies and the commissions – Finance and Health – have responded to those urgencies…I would like to make this point clear"* ***(Deputy Pablo Lorenzini, Congressional Hearings No.19.937, 20 November 2002).***

Although the President has discretion on the management of urgencies, interviewees did not mention this capacity as something distinctive in this reform. By contrast, several press notes covering the period commented that the potential change of urgencies was a game played by the Government to handle coalition struggles in the context of the legislative discussion. The following quotes from a newspaper capture the sense that this was key in the process,

> *"The increasingly politicised health reform was affected by another unexpected change. Although in the last days President Lagos and the Minister Artaza confirmed they will not*

[43] Legislation can be send by the Executive to the Congress with three degrees of urgencies: 1) "simple urgency" (*urgencia simple*), in which the bill has to be reviewed and delivery to the next chamber within 30 days. 2) "summa urgency" (*suma urgencia*) which had a deadline of 15 days. 3) "immediate urgency" (*urgencia inmediata*) that should be analysed and dispatched by the Congress within 6 days. However, the government can change the degree of urgencies any time and there are no sanctions if the Congress exceeds the deadlines.

*change the urgency of the bills, in private, La Moneda [Presidential Palace] negotiated a withdrawal of the urgency in exchange for a deal with congressmen from the commission of health and finance that defined a strict timetable of work. The Executive pretends to use this change of urgency as a more efficient way to face the opposition and to make the UDI accept publicly that they are supporting the ISAPRES" (**El Mercurio, 12 July 2002).***

*"What La Moneda did? They re-installed the urgency for the legislative process and when the government does this, as stated by a Concertacionist deputy, it is because they accept that there is a conflict" **(El Mercurio, 29 December 2002).***

A press note said that a couple of neoliberal representatives suggested the Government was using the urgencies to manipulate the voting process,

"The vice president and general secretary of the UDI, Carlos Bombal and Patricio Melero, respectively, said that the decision to withdraw the urgency from the health reform projects was a manoeuvre to damage the "gremialismo". They challenged the Government to get the initiatives approved in 30 days because they had the votes needed in the Congress to pass them quickly. This was demonstrated with the constitutional accusation of the provincial governor Trivelli.[44] *They have the votes – to approve the reform – and now they withdraw the urgency. They do not care about health, as they know we are available to approve in 24 hours if the government wants" **(Senator Carlos Bombal**[45] **quoted in La Nacion 13 July 2002).***

The debate about the urgencies continued when the reform advanced to the Senate, as they could not guarantee that they had the votes in the second legislative phase. President Lagos stated that he would have second thoughts about changing the agenda,

"Minister Garcia knows the efforts we must make to get the AUGE Plan working in 2004…there was a moment at the Chamber of Deputies when we did not need to put an

[44] This comment refers to a constitutional accusation presented by the *Alianza por Chile* against the DC governor of Santiago that was rejected by all the deputies from the *Concertación*, and therefore, was declared inadmissible.
[45] Carlos Bombal, a lawyer from UDI, was President of the Health Commission of the Senate until 2002.

urgency, but there was a commitment to get the projects approved in one period. But now in the Senate, we do not discard anything [in reference to a change of the urgency]" ***(President Ricardo Lagos quoted in La Tercera, 07 March 2003).***

Another formal capacity defined by the Presidential attributes was the organisation of a working procedure via the Inter-ministerial Committee that allowed him to control the policy process. As such, the advantage of the reformers was again substantially higher than other coalitions, as they accumulated expertise and technical capacity from ministries' teams. Specifically, Lagos sought to get the health and finance ministers and their advisors fully involved in the Congressional debate, where they represented Lagos' views.

In June of 2000, Lagos mandated the Health Minister to coordinate an inter-ministerial group to define the guidelines and deadlines for the health reform. As stated in the Public Administration Statute, a minister is a collaborator of the president, which conducts a Ministry and proposes national policies for executive consideration. In this context, Michelle Bachelet led the committee, comprised of ministers from the presidency as well as the Ministries of Finance and Labour, from 2000 to 2001 on behalf of the president to produce the contents of the bills. However, as explained in the previous chapter, President Lagos lost control over the Health ministry's agenda due to Bachelet's radical stand about the direction of the reform. The confrontation between the two coalitions within the ministry, reformer and radical, blocked the advancement of the reform. It ended when Osvaldo Artaza, who was able to deliver the reform package to the Congress immediately after the presidential speech in May 2002, was appointed as minister.

Once the projects reached the legislative phase, the president oversight over the policy process was performed by his formal representatives, the Ministers of Health and Finance. They defended the content and the economic feasibility of the reform against the neoliberal, radical and moderate parliamentarians. Strictly following the president's guidelines, both ministers and their respective teams were responsible for discussing the comments raised by parliamentarians and re-drafting accordingly. For instance, in the congressional sessions that were devoted to funding issues and the redistribution of resources, the Ministry of Finance presented technical reports demonstrating the economic feasibility of the bills ***(Congressional Hearings Law No.19.888 and Congressional Hearings Law No.19.937)***.

One of the interviewees highlighted a very interesting example of the coordination between Lagos and the Minister of Finance, in a strategy to gain support for the Authority Sanitary Law from politicians. The representative of this ministry, Marcelo Tokman explained that they decided to publish, at the end of 2000, a report about the deficiencies of the public sector in a volume of working papers from ECLAC.[46] This report called "Results and performance of public spending in the Chilean public health sector 1990-1999"[47] was written by Tokman and Jorge Rodriguez Rossi[48] (as members of the Office of Budget's department of research). The main goal of this publication was to call attention to the necessity of restructuring the public system and extending the reforms focus beyond the private sector. The paper showed data on the number of beds available in hospitals, records of attendance for doctors and health sector workers and other points which painted a negative picture of public institutions and services. This report was widely disseminated and criticised by health workers who claimed that the information was incorrect. They argued that the lack of resources and deficient administration of hospitals and primary centres was caused by the negligence of government authorities, not of public system workers.

The controversy created by this report was captured by press notes of the period. For instance, a headline from an article in the *La Nacion* newspaper read "The report that seeks to block the reform" and presented the opinion of two radical representatives, Juan Luis Castro and Soledad Barria. This article criticised the methodology of the document as well as the intentions behind its publication. According to the article, Juan Luis Castro said,

> *"There are groups from the economic area of the government who are very interested in delaying the health reform. The report is biased and incorrect, and it was published with the sole purpose of blocking the process"* ***(La Nacion, 06 May 2001).***

[46] Economic Commission for Latin America and the Caribbean, United Nations.
[47] Rodriguez, J. and Tokman, M. 2000."Resultados y Rendimiento del gasto en el sector publico de salud en Chile 1990-1999" Serie Financiamiento del Desarrollo Nº106 CEPAL.
[48] An economist from the PDC that was later appointed as a Minister of Mining, and then as a Minister of Economy during the Lagos administration.

Furthermore, this report also provoked a conflict with Minister Bachelet, as she had to defend the public system even when it was being criticised by the governments' own employees. A press note outlines what the minister said about Tokman and Rodriguez's paper,

> *"Minister Bachelet made a strong defence for the public health system in the last decade, in terms of productivity and sanitary goals. Even though she declined to comment on the report of the Ministry of Finance's specialists, she indicated that it was not good to calculate the productivity with one or two factors, and estimations must include quality factors. She also stated that it is a mistake to say that there is a lack of productivity in public institutions, saying that these comments only affect people that use public services"* ***(La Nacion, 15 May 2001).***

This publication legitimated and generated consensus about the restructuring of the public systems, as "it was the voice of the experts". Specifically, the Health Authority Law (Law No.19.937) was approved by a majority. However, these facts unveiled that the influential role of the Ministry of Finance actors lessened the authority of the Health Ministry, as it was confirmed by one of the informants,

> *"Because in the end, the Ministry of Finance makes the decisions, and this is indicative of where the centre of power was… decisions were not made in La Moneda [presidential palace] but in the Ministry of Finance…The Minister of Finance mandated Marcelo, and he was the negotiator within the Government…In the end, public policies decisions are always made by Finance; no matter who the proposal is coming from"* ***(Sanchez 2013).***

In a context where there was a strong president supervising the process and an influential minister of finance, the capacity and autonomy of the minister of health was diminished. Indeed, the second Minister of Health, Osvaldo Artaza, conceded that, due to Lagos' involvement, he felt displaced in his role as leader of the inter-ministerial committee,

> *"I said to you that, theoretically, the one who led the inter-ministerial committee was the Minister of Health. That was in theory. In the reality, the one who led the committee was the president himself. The president attended each session of the Committee. That gives you a very clear idea about his interest in the reform. So, what could the minister of health*

do in a meeting if the president was there? With his personality and irascible character? The one who always led the inter-ministerial committee was the President" ***(Artaza 2014)***.

Employing an informal resource, President Lagos cemented his power over the ministry when he established an ad-hoc organisation to prepare and to follow-up the reform proposal in parallel to the Health Ministry's work. He appointed Doctor Hernan Sandoval, his close friend and an expert in public health, as an executive secretary of the Inter-ministerial Committee in June 2000. Sandoval's appointment caused controversy, as it was interpreted as Lagos taking control of the reform at all levels and showed will to exercise his authority beyond formal institutions. The role of Sandoval and his friendship with the president became an obstacle for Bachelet's agenda, which defended a radical change in the health system. This conflict ended with a cabinet reshuffle that kicked Bachelet out of the Ministry. After this change, Ministers Artaza and Garcia were able collaborate with Sandoval in pushing the reform forward, in tune with President Lagos plan. A member of the reformer coalition said,

"Lagos made "a jugada" [a strategic decision], he said: Michelle has to stay there [at the Ministry] doing specific work. And you [Sandoval] are responsible for the reform, which is the only thing that matters. The problem was that this design did not work well…As Michelle did not like the AUGE, she had problems with Sandoval…because they both had different standpoints, and the reform did not progress…Then Lagos said, I need to solve this internal conflict and I am going to designate a minister that does not eclipse Sandoval, so they can work together" ***(Inostroza 2014).***

In contrast, a couple of interviewees from the reformer team mentioned that Sandoval's nomination had positive goals and effects, as it took pressure off the Minister and allowed her to be focused on managerial issues. Ottone, an advisor to Lagos, explained that they chose to have another group in parallel to the Ministry because,

"We needed a different structure, one that worked with the ministry but outside the Ministry, with a different logic, with another composition, which was not linked with the public administration, and without corporative pressures…with enough liberty from the bureaucracy, corporations, unions…You needed a place from where you could provoke an earthquake and not a place of confusion. That is why we had a different group with Sandoval as the leader of a professional group…" ***(Ottone 2013).***

The last aspect, on which the majority of the interviewees agreed, was that the leadership, personality, and commitment of Ricardo Lagos to get the reform approved by all means, was something distinctive from other presidents and other social policy sectors. The analysis of the data suggests that it was a combination of informal characteristics and formal procedures in which the president got involved that contributed to the success of the reform. A quote from a reformer coalition member captures this idea,

> *"This excessive presidentialism, it was indeed in our favour…In our case, Lagos always wanted to say publicly: this is my reform, and is part of my legacy, my stamp!...He was a president who asked every fifteen days how everything was going and how the negotiation with ISAPRES and the unions was going. Lagos was omnipresent in every detail…and he fought with everyone needed, e.g. Colegio Medico, with ISAPRES, as long as he could get his reform approved"* ***(Inostroza 2013).***

8.4 THE ELECTORAL SYSTEM AND THE COMPOSITION OF THE CONGRESS

Even though the Constitution concentrated legislative powers in the executive branch, the president was also forced to negotiate with parliamentarians, as the governmental agenda has to be authorised by legislation enacted in Congress. As such, the feasibility of the health reform depended very much on the majorities inside Congress, the minimums require, and on the ability of the Executive to garner support within the political parties, and for that reason, the mechanism for distribution of seats in the Congress was considered as a constraint for policy making and coalition interplay. Particularly, one of the consequences of the binominal electoral method for parliamentary elections, was the exclusive representation of the two electoral alliances that contained the main political parties, *Alianza* and the *Concertación,* result that, as I explained in Chapter 2 this system over represent the second majority even when they just get 33,4% of the votes. The purpose of this mechanism, designed during the dictatorship, was to exclude those outside of these groups, such

as the Communist party and other smaller parties who had seats in Congress.[49] As noted by a representative of the Radical Coalition, while Lagos, during the presidential campaign, promised a more radical change to the health workers unions, once he got elected, he had to adapt his programme to the results of the parliamentary elections. Although the results of the elections were somewhat predictable under the binomial system, the CONFUSAM leader commented,

> *"The electoral system allows this equilibrium, to maintain the forces in Congress…at that time, there was a virtual draw between the government and the right. In spite of the Concertación getting 60% of votes and the right 40%, as a result of the electoral system, there was a technical draw. Therefore, the authoritarian enclaves gave the right the tools it needed to have this political equilibrium, to block the reform that Lagos promised us at the beginning"* ***(Maturana 2014).***

Table 14 shows the distribution of seats in the Congress during the period examined.

Table 14 Distribution of seats in the Congress (2000-2006)

Political Parties Conglomerates	Deputies	Senators
La Concertación	62	18
Alianza por Chile	57	16
Independents	1	3
Appointed senators		8
Lifetime senators		1

Source: www.elecciones.gov.cl

At the time, the president sent the health reform to Congress, the *Concertación* had a majority of 4 votes over the right-wing political parties in the Chamber of Deputies, which potentially gave the advantage to the reformer coalition. However, despite the majority, the debate in the Lower

[49] See Chapter 2 for an explanation of the binominal system.

Chamber was extremely conflictive for the centre-left pact. Jose Antonio Viera Gallo, a former Socialist senator, recalled his meetings with parliamentarians from other centre-left political parties,

> *"When the project reached the Lower Chamber, me and the rest of the Concertación parliamentarians, had weekly meetings to discuss the bill…but such was the level of discussion, the conflict was mainly between those deputies who were doctors and the government, so I decided not to go again. My thought was: I am going to see what I can do as a Senator in the Senate, not here…and then I decided to go away from these debates between deputies because it was too ideological"* ***(Viera Gallo 2014).***

Specifically, the difficulties for the reformer coalition came from the permanent health commission in the Lower Chamber, which was the place where the proposals were reviewed and analysed in-depth.[50] In the Chamber of Deputies, the health commission was composed of a group of 13 permanent members nominated by the president of the Senate (previously agreed with political parties). As expertise in the subject was relevant, deputies with medical background were usually nominated in this committee as the following table shows:

Table 15 Distribution of political parties in the health committee, Chamber of Deputies.

3 PDC	2 PPD	1 PS	1 PRSD	3 RN	3 UDI
Carlos Olivares (Doctor)	Enrique Accorsi (**Doctor)**	Sergio Aguilo	Alberto Robles **(Doctor)**	Francisco Bayo **(Doctor)**	Marcelo Forni
Sergio Ojeda	Guido Girardi **(Doctor)**			Maria Angelica Cristi	Patricio Melero
Patricio Cornejo (Doctor)				Osvaldo Palma **(Doctor)**	Juan Masferrer

Source: www.camara.cl

[50] These committees are composed by parliamentarians nominated from a names' proposal by the president of the respective Chamber, in agreement with political parties. Most of the time, this group makes decisions that informally bind the votes of the rest of the parliamentarians.

Due to the linkages between *Bancada Medica* with professional and health workers associations, the defence of their interests in the Lower Chamber became an obstacle for the government. In this committee, the confrontation between radicals and reformers was clear. As ex-Minister Artaza said,

> *"The health commission [in the Chamber of Deputies] was comprised a majority of the Concertación members. Therefore, we had the votes to pass the bill quickly. But there was no cohesion on how to vote…but, there were at least five deputies that were doctors, such as Accorsi, Girardi…and they were completely aligned with the Colegio Medico and against the reform"* ***(Artaza 2014).***

A press note from the period indicated,

> *"The reform was sent to Congress in May, and the parliamentarians from the Concertación made a commitment with Lagos and Artaza, to get it approved in the Lower Chamber and then to dispatch it to the Senate in December. But, it seems that the commitments are made to be broken, as Deputies Accorsi and Cornejo led a mini-insurrection and they decided not to pass the initiative because, they said they wanted to hear the voice of the unions"* ***(El Mercurio, 29 December 2002).***

Although my interviewees and the press notes indicate that the first legislative phase in the Lower Chamber was highly polarising and a real obstacle to advance in the reform, due to the opposition of politicians within the *Concertación*; members of the reformer team recognised that the debate at the Chamber of Deputies was not a crucial step for the bill, because most decisions would be made in the Senate. A quote from one of the advisors explain,

> *"The strategy defined by the SEGPRES was to quickly go to the Senate, to negotiate and to get the reform approved unanimously; and then go back to the Chamber of Deputies, to impose. Therefore, it did not matter how the bill would come out from the Chamber of Deputies [in the first legislative step]. It did not really matter. We made concessions to deputies because, after all, we could re-write the whole bill"* ***(Romero 2013).***

Furthermore, the statements transcribed from the legislative discussions showed that while there were comments and indications about specific articles of the bills, deputies finally agreed with "the idea to legislate" and therefore, they passed the project to the second legislative step. For

instance, the deputies approved bill 19.966 about the AUGE Plan with 89 of 120 votes[51] that were in the Congress in December 2002, with no abstentions or rejections. In the third and final legislative round at the Lower Chamber in January of 2004, they approved the proposal with 103 votes in favour, one abstention (Girardi), and one rejection (Accorsi).

In the Senate, because of the non-elected senators, who were not explicitly aligned neither with the *Alianza* or the *Concertación*, there were no clear majorities. In this context, the reformer coalition had to focus their efforts on securing the votes of people within and beyond the *Concertación* to pass the health reform bill. Reinforcing this idea, Inostroza said,

> *"Remember Lagos still had the appointed senators… with those senators close to the right, they had the majority to block the reform. We had a majority in the Chamber of Deputies but not in the Senate. Therefore, we were forced to negotiate in the Senate. That was the option we took to get the AUGE approved"* ***(Inostroza 2013).***

In 2002, the composition of the group of non-elected senators was the following: three of the appointed senators designated during President Eduardo Frei's administration were part of the *Concertación* parties: Augusto Parra (PRSD) and Edgardo Boeninger (DC), along with Enrique Silva-Cimma (PRSD) as the ex-General Comptroller. The rest of the senators did not declare a political affiliation, and presented themselves as independents; however, as they were former military commanders during the dictatorship, it was assumed they had strong ties with the right-wing parties.

Though the perception was that the designated senators were always at the service of the right-wing parties, the designation of Boeninger in 1998 and Frei (as former president) in 2000, changed this scenario. With these non-elected senators from the Christian Democratic Party, the Lagos administration would have their votes for the health reform. However, during the political discussion, both senators were strong opponents of those aspects of the reform related to the funding proposal for social policies. While Boeninger became a supporter of the reform later on as

[51] As an ordinary law, this bill just required a simple majority and did not require a minimum of deputies in the Congress.

a broker of the pragmatic coalition, Senator Frei voted against tax increases causing the majority to reject the measure, against the party's decision. As President Lagos recalled,

> *"When I tried to get funding for the reform, increasing alcohol and tobacco taxes, Frei voted against me…oh my god! That was too much for me! A Senator of the Republic was voting against these tax increases…Finally, we had to choose an alternative solution, to raise the added tax value, which was absurd…"* ***(Lagos 2013).***

Besides this, the capacity of reformers to manage the minimums needed to vote the bills through was also very important. Interviewees did recognise that the requirements of votes were a legacy from the authoritarian regime as it had defined the majorities needed at the Congress, which was determined by the results of the binominal system.

The health reform package was a set of laws that required a simple majority; therefore, the reformer coalition needed to have the votes of the majority of parliamentarians in Congress at the moment of voting. Because of that, a few respondents emphasised that the role of Eduardo Frei was also crucial for the discussion of this bill, because he was not present during the last period of the reform debate due to illness. Therefore, right-wing politicians took advantage of his absence to demand modifications to the bill. In this context, some interviewees noted how quorum differences affected the health reform. For instance, they pointed out how "Ordinary laws" differed from ones called "Organic Constitutional Laws"[52] that required the approval of four sevenths of Congress (i.e., 69 deputies and 22 senators) and the "Qualified Quorum", which needed an absolute majority of Congress members. Hernan Sandoval remembered that,

> *"There was a threat from Hernan Larrain [a UDI senator] about converting the ISAPRES bill to a bill within the social security laws that, since Jose Piñera*[53]*, are laws which required a "qualified quorum" and we had at that time designated senators, and Frei was recovering*

[52] See section 2.3.3 regarding the Constitutional laws and quorums defined in the Constitution of 1980

[53] Jose Piñera was a Minister of Labour and the main promoter of the social security system reform that determined the privatisation of social policies under the authoritarian regime. The introduction of the ISAPRES in the health sector should be understood as part of this scheme.

from surgery, unable to move. And that made everything worse for us…" ***(Sandoval 2013).***

In contrast, Andres Tagle, a neoliberal member, strongly rejected the idea that the electoral system had determined the result of the health reform. He stated that the project did not require a high majority,

"This thing about the draw at the Congress, it has never been true. The electoral system never produced a standoff. Furthermore, the electoral system has been very proportional. In the case of the health sector, there are no organic constitutional acts, so they work with simple majorities in the Congress. That is the only thing that counts" ***(Tagle 2013).***

Even though the informants suggest that electoral mechanisms affected the policy process of the health reform, the bills, after the incorporation of changes from the Health and Finance Committees, were finally passed unanimously by the senators. The reform was then approved in the Chamber of Deputies, in the last legislative step in May of 2005.

8.5 SUMMARY

The last chapter of the findings aimed to analyse the data on some of the stable parameters and opportunities structures in the Chilean political system that were put in place during the authoritarian period, and how they affected the course of health policy reform. The first section reviewed the feasibility of reforms, and their dependence on the heaviness and the deep-rooted nature of institutions in a new political scenario. It was mentioned that the privatisation of social policies during the eighties created powerful institutions, such as ISAPRES. Some of the initiatives that were included in the health reform were intended to improve the regulatory framework and administration of private and public institutions. In addition, this structure of power also impeded the formation of constituencies around the health sector to challenge the unfairness of the system.

In the second section, and regarding the presidential attributes, the Constitution of 1980 intensified the power of the president. According to the data, Ricardo Lagos exercised his authority in promoting the health reform via his legislative initiative and the management of urgencies. He also utilised informal venues to supervise the policy process and to the battle opponents of his agenda with the appointment of Hernan Sandoval. Furthermore, informants commented that President Lagos's personality made a difference in the reform outcome.

The last part analysed the binominal system and the distribution of seats in the Chamber of Deputies and the Senate. While, in the Lower Chamber, the reformer coalition had a majority, the discussion and process was very conflictive due to the opposition of radical members in the *Concertación*. In the Senate, the existence of appointed senators and quorums required posed challenges for the reformer coalition. Nonetheless, as the centre of the discussion was the permanent health committee, where its members were driven by consensus-building, the process was able to move forward. The outcomes of the final vote on the AUGE Plan bill in the Senate confirmed that, although the *Concertación* did not have majority, they did manage to garner the necessary votes to pass the reform.

The concluding chapter will discuss the findings within the context of the broader literature, as well as the specific theoretical and empirical contributions of this thesis.

CHAPTER 9 DISCUSSION AND CONCLUSION

9.1 INTRODUCTION

The previous three chapters considered the results of the Advocacy Coalition Framework analysis of the health policy reforms in Chile. As stated earlier, many have argued that after the political regime change in 1990 the policy process in Chile, due to the constitutional arrangements set up by the Pinochet dictatorship, has been characterised by inertia. This inertia has favoured the stability of the socio-economic model created during the authoritarian years and the inability to bring about radical changes. Considering this context, this research aims to answer the question: How was the health reform during the Lagos administration between 2000 to 2006 achieved within the institutional arrangements that had been put in place by the Pinochet dictatorship? In answering this query, a qualitative case study was conducted to examine the policy process within this period. Data collection and the documents review were informed by previous ACF studies and literature on health policy reforms focused on post-authoritarian regimes (Kaufman and Nelson 2004; Castiglioni 2005; Wong 2006; Haggard and Kaufman 2008, among others). This literature helped me identify my sample of interviewees and design the interview schedule. Driven by the ACF assumptions, a largely deductive thematic analysis was conducted of the 26 semi-structured elite interviews and transcriptions of congressional hearings.

The results of the data analysis suggests that, in spite of the post-authoritarian inertia in the policy field, approval of the health reforms was achieved via a “negotiated agreement” as one of the policy change paths suggested by the ACF. Therefore, this final chapter discusses the main findings that emerged from the data analysis and the appraisal of the relevant ACF literature. The chapter is structured as follows: the first section begins with a discussion of the findings related to policy change and the path adopted in the Chilean case. The next three sections appraise the findings regarding the dynamic configuration of advocacy, followed by an exploration of the use resources and strategies by coalitions, and finally, the effects of institutional arrangements and policy legacies are examined. In closing, the main contributions and limitations of this research are considered, and areas for future studies applying the ACF approach are suggested.

9.2 UNDERSTANDING HEALTH POLICY CHANGE IN CHILE

Using the empirical data provided in previous chapters and the theoretical contribution of the Chilean case to the ACF about the policy change conceptualisation, two main topics were identified. On the one side, and the one related with the drivers or sources of policy change as it is presented in the foci of the ACF; and, on the other side, the one which refers to the discussion about to what extent the health reform in Chile represents a major policy change, and not an incremental one as it is suggested by historical institutionalists in the post-authoritarian period. As the latter is concerned, academic efforts to create a definition of what is radical or incremental (the replacement of older institutions by new ones), for instance, the work of Streeck and Thelen and (2005), or the definition of universalism coverage proposed by Pribble (2014) to define a degree of change, is explained in the last section of Chapter 2. The debate about what kind of change can be typified as major/radical versus minor/incremental, was a query of concern when I was doing my research as, at first, my perception about the reform was closer to the incremental perspective of the historical institutionalism, this is as the mixed structure of the system of private and public providers remained identical after the reform. Nevertheless, the more interviews I did the more I changed the perception about the scope of policy change.

The ACF conceptualisation of policy change permits the understanding of how the health reform, as a major shift can be understood. One of the fundamental premises of the ACF is that coalitions are kept together by belief systems, and this has been the focus of many applications of the framework (Weible, Sabatier, and McQueen 2009). As explained in Chapter 3, there are three levels of beliefs identified in this approach: deep, policy core and secondary. The deep core beliefs, which are based on notions of human nature, are extremely resistant to change. As Henry (2011, 36) points out, this leads "to situations where coalitions of like-minded policy actors entrench themselves in ideological bunkers and talk past one another policy issues." The policy core and secondary beliefs are more adaptable under specific circumstances. If issues are perceived as less conflictive, coalitions are more likely to be willing to adapt their views (Zafonte and Sabatier 2004). In this case, it is important to understand what the sources of division between the coalitions were, or in words of the ACF, what the beliefs they shared were. The findings show that, in the Chilean health sector reform, the coalitions' positions were directly related to the post-dictatorship political cleavages of Chilean society. The division of society was marked by the divergent views of liberty and equality, the role of the state and the market in the economy, and, to a large extent, about

whether they supported or opposed the Pinochet regime when it was in power. That would be the deep core beliefs, and, as it is expected, almost impossible to be radically changed. Considering this, major policy changes could be taking place at the policy core level, which is precisely what my findings shows.

The results of the data analysis suggests that although the system is still divideed into both public and private (following deep core beliefs' cleavages), the enactment of a new set of laws regarding the provision and regulation of healthcare in Chile since 2005, represents a major policy change in how the subsystem is perceived. For instance, the fact that there are new principles that impose higher levels of regulations for private insurance companies, and the delivery of health services in a frame of social right were transformations that according to most of the interviewers, can be seen as a radical departure from the system established by Pinochet. One could say therefore, that the simple enactment of a new legislation package that increases regulation and a new way to deliver services in the long term can be measured as a major change, different to technical and small adaptations of the same legal framework that reiterates new policies whichtend to maintain the status quo.

Various respondents emphasise that there is no chance for any future to revert the AUGE Plan, as people are now aware that they are right holders with the capacity to demand that both private and public institutions should fulfil their principles of access and guarantees. This became a new empowered constituency, which in Chile has means and increases the judicialisation of health, where users are presenting lawsuits in courts against private insurance companies to make them act according to the new laws enacted during the Lagos mandate. As such, the combination of rights and constituencies create a path which has become dependent and difficult to revert. Interviewers emphasis that there is a precedent for public policies, and other social sectors must replicate the guarantees of access of AUGE, for instance an educational AUGE.

The second issue as a main contribution of this study is to understand policy change from the Chilean case is the explanation about how this major policy change was reached. In explaining how policy change occurred, the ACF and a other institutionalist (Hall 1993; Pierson 1996, 2000; Streeck and Thelen 2005) and public policy scholars (Kingdon 1984; Kingdon 2003; Baumgartner and Jones 1993; True, Jones, and Baumgartner 2007) have argued that transformations are a result of external shocks, which break the stability of political systems. In this way, the political transitions occurred during the 80s and 90s in Latin America, Eastern Europe and Asia have been

seen as shocks that opened windows of opportunity for the implementation of change in various areas. However, research indicates that the routes, times, and mechanisms of policy change are wide-ranging, as they depend on the type of regime change and the nature of the political legacies inherited from the authoritarian periods (Haggard and Kaufman 2008). The effects of democratisation on the pace of reforms are not uniform, rather they are complex and linked to the particularities of domestic political features (Kaufman and Nelson 2004; Haggard and Kaufman 2008).

To unravel the complexity of the policy process, the ACF proposes three other paths of policy change (Studlar and Cairney 2014). These are internal shocks, policy-oriented learning, and a negotiated agreement. The argument of the ACF is that any of these sources of policy change may induce an alteration of a coalitions' belief system and promote an understanding of the issue that increases the feasibility of policy change (Sabatier and Weible 2007). Despite the increased theoretical development of these new paths, many scholars using the advocacy coalition perspective in countries that have experienced political regime transitions have continued to argue that policy change is explained by events outside the policy subsystem. For instance, the study of flood management in Hungary conducted by Albright (2011) and the study on the development of water policies in Spain carried out by Bukowski (2007) demonstrate that democratisation and accession to the European Union were crucial to explaining the policy change outcomes in both subsystems. In contrast, the results of the data analysis conducted for this research show that a different path to policy making was operating in the health sector. The theory of external shocks does not adequately explain policy making during democratisation or the momentum that, in some circumstances, can stimulate transformation in a policy subsystem such as health. In this case there were no specific exogenous shocks that increased the pressure for a major policy change in the sector. In contrast with the general trend in post-authoritarian countries (Kaufman and Nelson (2004), international institutions, such as World Bank (WB) or the Inter American Development Bank (IDB), were not a source of pressure for policy reforms in Chile at that time.

The results of the data analysis suggests that, in spite of the post-authoritarian inertia in the policy field, approval of the health reforms was achieved via a "negotiated agreement" as one of the policy change paths suggested by the ACF. What the findings from the analysis do support is that the approval of the health reform in Chile, a major policy change, was reached through negotiated agreement and, to a lesser extent, through policy-oriented learning. As far as the former is concerned, ACF scholars stress that achieving agreements requires compromise and the will of

coalition members to reach the best solution for a certain policy problem (Schlager 1995). Sotirov and Memmler (2012, 53) summarise four conditions that stimulate a collaborative approach: 1) mutual dissatisfaction with the status quo; 2) the absence of promising alternative institutional venues; 3) the promotion of collaborative trust and commitment; and, 4) an inclusive decision-making process and independent mediators.

In Chile, the economic stability reached during the nineties left the *Concertacion* government with a good and sustained financial base to be independent of external loans and therefore, as the interviewees responses suggested, the influence was likely in the ideas about the content rather than direct control over the design of the Plan AUGE , as the first wave of reform in the post authoritarian context was marked by the neoliberal trends and focused on the poorest, in the first decade of the 21st century there was a promotion of more equitable goals, stressing the need of more solidarity and wide scope of beneficiaries of social policies. Although external forces are not an explicit source of change according to the findings, it is possible to identify that beliefs of the International Organisations were disseminate to the Chilean policy makers through previous collaboration, in particular, some of them who worked as a consultancy as it is explained by former Minister Jimenez and the advisor of the Minister of Finance, Consuelo Espinosa, which is elaborated in section 9.4 of this chapter.

Another external event considered in the literature is the wave of presidential elections in Latin America. While the "turn to the left" in the regional governments during the 2000s is a contextual feature mentioned by Ewig and Kay (2011), Pribble (2013) and Gideon (2014), the research findings do not support this as a causal mechanism for the Chilean health reform, as governments took different paths and degrees in reforming their health systems (when they did). It could be said then, that the influence of external forces did not become a sufficient promoter of policy change in the Chilean case, in turn, it could be considered as part of the beliefs system of some participants in coalitions, who supported the ideas presented by the international organisations or the ideological positions of leaders in the region. In that way, the indirect guidance can be analysed within the coalitions´ structures and not as an external driver. Nonetheless, this is a topic of study that could be explored in-depth as part of future research that explores specifically the role of international institutions through the lens of the ACF either as exogenous factor of policy change or within policy subsystem.

In terms of internal aspects, it is true that there was a build-up of problems in the health sector and there was a change of president. But, both factors were also present in the first two governments of the new democratic period and did not result in a political decision to implement a comprehensive reform. The findings do not provide evidence of internal shocks either, as the proposed reform responded to long-standing issues in this area, but not to a particular event that raised the concern of authorities.

The reasons how the negotiated agreement path was achieved are assessed in the following three sections, answering the sub-set of questions posited in the introductory chapter: What was the role of coalition structure in explaining the policy change? How did the distribution of resources and the use of various strategies influence policymaking in this case? How did institutional arrangements and policy legacies affect coalition interactions? The answers to these queries will be explored further in the discussion of this thesis, taking the issues that emerged from the review of existing ACF literature, specifically, those studies dealing with post-authoritarian cases into account. In the Chilean case, the findings provide evidence that this agreement was reached by a combination of three factors: an evolution of coalitions that pursued a consensus-building strategy; the use of formal and informal resources and venues to influence the policy process; and the skilful exploitation of the institutional arrangements in Chile's post-authoritarian political system.

9.3 SHIFTING COALITIONS OVER TIME

The clash of interests from various political actors precisely corresponds to the political dimension of health reforms (Walt 1994; Moran 1995; Gonzalez-Rossetti and Bossert 1999). In the Chilean case, as different individuals and organisations sougth to influence the decision-making process as the process unfolded, there was a clash of interests from various political actors, a different picture of what Garreton (2003) called "the apparent consensus" during the *Concertación,* which implied that there was an absence of debate about various aspects of Chilean politics (for instance, human rights and economic transformation) by the governmental authorities. The accounts provided by the media documents on the health reform during the Lagos administration and the informants of this study demonstrate rather a different picture from what Garreton (2003) described as a consensus. They indicate that this process was characterised by high levels of

conflict and debate among political and economic elites, which only later evolved into an agreement.

While most ACF studies in long-term democracies and post-authoritarian regimes show a configuration of two advocacy coalitions (in favour and opposed), a few have identified a greater number of actors that coalesce around different issues within a policy subsystem (Carvalho 2001; Albright 2011). Further, a few ACF studies have examined cases in which coalitions evolved over time, generally showing a pattern of stability in which the same configurations of coalitions remained steady in the long term (Leifield 2013; Zafonte and Sabatier 2004).

In this regards, this research differs from previous applications as the analysis identified four initial competitive coalitions that shifted into one pragmatic group, a shift that fostered the health policy reform. The evolution of the Chilean coalitions occurred in two phases. The first period began with the announcement of the reform by President Lagos in May 2000 and ended, after the initial discussion in the Chamber of Deputies, when the first bill in the reform package was submitted to the Senate for consideration. The second period began with the discussion in the upper Chamber in January 2003 and ended when the last bill (Law N° 20.015) was approved in the third legislative step, in May of 2005. The identification of coalitions, based on the outcomes expected (major or minor change), shows that actors were organised as follows: The "reformer" coalition comprised of the government that had proposed the initiative. This coalition had to face the opposition of three coalitions: the "radicals", the "moderates" and the "neoliberals", which held clearly distinguishable beliefs during the first period. In the second phase, there was a merger of some of these adversaries with governmental actors. This merger resulted in a new and unique coalition that facilitated the path for the bill approval. This coalition, which has been named the "pragmatic", was comprised of actors that previously challenged the reformers' plan, a team of authorities and advisors from the executive branch, plus a former radical (Senator Mariano Ruiz Ezquide), a previous neoliberal (Senator Evelyn Matthei), and a moderate (a designated Senator Edgardo Boeninger).

The neoliberal coalition was composed of supporters of the free market, who emphasized the value of individual freedom and capacities, and defended Pinochet's accomplishments. The beliefs in the other three coalitions were similar to the formation of the *Concertación* as an electoral pact. Coalition members from the Centre-left pact, adherents to Socialist (PS), Radical (PRSD) and people from the Party for Democracy (PPD) defended social democratic principles and rejected the

legacies of the military regime. The internal dissonances between the Christian Democrats (DC), also part of the centre-left pact, with the more progressive parties such as the PPD and PS was a constant source of conflict during the first phase in the health reform discussion. The disagreements with the DC were based on the degree of state intervention in economic issues, as well as moral value matters (deep core beliefs which rarely change), which were permanently vetoed by the DC. In fact, as there were no policies about reproductive rights in the Lagos reform package (although, in parallel to this debate, there was a discussion regarding the distribution of the emergency contraceptive pill), the initial opposition of the DC members to the reform was mainly economic.

In the case of the other components of beliefs systems, data from this Chilean case suggests that policy core and secondary aspects were translated into the outcomes expected by each coalition and thus were more malleable than the deep beliefs. Members of the right leaning coalition, the neoliberals, were seeking to protect their health market businesses against the regulatory and redistributive policies proposed in the original reform. The group of parliamentarians from the Christian Democrats held an opposing position, as they defended the interest of the private entrepreneurs, but supported social policies for the poor and middle classes. Finally, the radicals wanted to return to the state-based health system before the reform of 1981. Reformers sought to persuade all of these groups, proposing an expansion of social rights within the dual system, providing guarantees for access and opportunity, and protection against market failures. The internal conflicts and the fragmentation of the political power in the *Concertación* were strategically used by the neoliberal coalition which, as mentioned by a few interviewees, decided to stay away from the discussion in the Lower Chamber. In this situation, the reformers had, in the first stage, to manage the disagreements between the centre-left parties and *La Moneda.*

Coalitions may shift, as Zafonte and Sabatier (2004) indicate, as changes in their policy core beliefs and secondary beliefs might occur through policy-learning. This is an instrumental process by which coalition members are able to modify their understanding about an issue when new information enhances their standpoints. The findings show that policy learning did not occur in the first stage of the discussion, and that it was during the discussion in the Senate where the positions of pragmatic coalition members came closer together. In the Lower Chamber, the main feature of the discussion was the disagreement on several points of the reform proposal. While health workers were defending the status of their jobs within the radical coalition, neoliberals sought to stop regulation that could affect their commercial investments. Due to the high levels of

conflict within the Lower Chamber, agreements and adaption of beliefs systems were not plausible alternatives. However, despite the disagreements and the lack of commitment from some *Concertación* parliamentarians, at the end of the discussion in the Chamber of Deputies, the bills were passed to the Senate almost unanimously. According to the respondents, some factors allowed the proposal to obtain the necessary votes to advance to the next legislative stage. Critically, President Lagos suggested that nobody had the courage to reject the bill in Congress, as politicians were aware of the electoral consequences, in the following elections, of appearing to be an opponent of the reform.

In answering the question: what was the role of coalition structure in explaining the policy change? It is be possible to say that, in the first phase, the core beliefs remained steady, as coalitions were constantly struggling to shape the bill according to the outcomes they sought. However, the data reveals that not all the coalitions could exercise their power in the same way throughout the process. At a certain point, the debate moved from the Lower Chamber to the Senate, where the control of discussion was limited to a reduced number of Congress members and health committee members, which prompted the formation of a single coalition that pushed the bills forward.

Additionally, in the second phase, collaboration was achieved because the government agreed to leave out the Compensatory Fund, which was seen as the main obstacle for neoliberal and moderate members. Once it was taken off the agenda, internal conflicts were minimised and the pragmatic coalition consolidated the negotiation to push the reform forward. There was also a situation of "hurting stalemate" where the lack of alternative courses of action increased the chances of collaborative actions among coalitions (Schlager 1995; Sotirov and Memmler 2012). Actors in the Senate realised that the reform was definitely going through and that delays would not be acceptable, and therefore, they took actions accordingly. As such, compromise, as a key element of the negotiated agreement path (Schlager 1995), was prompted by the cabinet reshuffle in which Osvaldo Artaza was replaced with Pedro Garcia as Minister of Health. Information from the interviews indicates that this encouraged the commitment of rest of the actors in the Upper Chamber. Some respondents indicates that this engagement was facilitated because new Minister Garcia's personality was less confrontational than Artaza's; acting more as an administrator of the process rather than a leader of the reformer coalition. This is not to say that he was a weak authority, but to acknowledge that in the second phase, he was more compliant to the Presidency's instructions than previous ministers. What is interesting to note, is that the ministerial

authority did not directly lead the negotiation in the Senate. As will be demonstrated in the next section of this chapter, this was in the hands of policy brokers.

9.4 RESOURCES AND STRATEGIES

While the creators of the ACF state that resource mobilisation is a key component of advocacy coalitions and provide a typology of the sources of power (Sabatier 2007; Jenkins-Smith et al. 2014), only a few studies explore these strategies and the use of power resources by coalitions aiming to change existing policies. These include the analysis conducted by Larsen et al. (2006) on pharmacy policies in Denmark, Nohrstedt (2011) on Swedish on intelligence policy, and a study of an environmental project in China, carried out by Han et al. (2014). This study contributes to this body of literature by providing an elaboration of both factors: the use of resources and strategies in the policy process. It explains how they affect the evolution of coalitions and the implications they have for policy change. Findings of this section answer the second specific question: How did the distribution of resources and the use of various strategies influence policymaking in this case?

As the ACF would predict (Sabatier and Weible 2007; Sotirov and Memmler 2012), every coalition involved in the Chilean health reform carried out a series of coordinated activities, employing their own set of resources and power, attempting to put their interests on the political agenda and disseminate their views. The mobilisation of resources was mainly directed to three strategies: first and widely used by all coalitions, was the search to influence public opinion; second, the use of information/expertise; and third, the exploitation of skilful leadership by appointing key people as policy brokers in the Senate. The management of public opinion, where they tried to influence the citizens' views about the reform, was the main strategy employed by coalitions during the first phase. In the second phase, the main goal of the pragmatic coalition was building a consensus and they employed two particular strategies to this end: a consolidation of a piece of collaborative work between authorities and advisors; and second, an engagement of policy brokers, who were formerly members of other coalitions, to take charge of the negotiation.

The reformer coalition had a considerable amount of resources in comparison to the rest of the coalitions. For instance, the formal power to make political decisions, the accumulation of knowledge within governmental advisory teams, and, in this case, investing public resources to develop communicational campaign, as well as to pilot the AUGE Plan. The public campaign

conducted by the government, which argued that the AUGE Plan was a tool to defend patients from the "inefficient- white –elephant" of the public sector and from the "unfair cover" of ISAPRES, proved to be effective at generating support. Reformers adopted the strategy of "going public" (Kernell 1997), rather than trying to convince deputies and political parties within the *Concertación,* even though they were major obstacles in the first phase. It was in the Senate that reformers put their efforts into gathering support from adversaries. Another strategy used by the reformer coalition which increased popular support, was to implement a pilot of the AUGE Plan before it was legally enacted. The mobilisation of these resources certainly facilitated the position of reformer coalition in the policy process, but did not ensure the approval of their plan.

Members of the radical coalition, who advocated for a return to a public health system, also "went public" through a broad media campaign against the government and focused on the former Ministry of Health, Osvaldo Artaza. In reaching the attention from public opinion about the inadequacies of the reform, doctors and health workers organised strikes and demonstrations particularly during the legislative debate. However, their message was perceived rather as a vindication of their autonomy and privilege within the public-private scheme of the health system; rather than a defence of the citizens' rights. The strategies like strikes and demonstrations used by professionals and technicians working in public hospitals and primary centres as a way to pressure authorities, seemed to be fruitless when it came to get public opinion support because patients were the ones affected by these types of actions provoking the rejection to their cause. Consequently, they lost influence and control of the agenda over the reform' discussion due to their obstructing behaviour, being excluded from the key decision-making arena that mainly took place in the health committee at the Senate.

The neoliberals, as can be seen from the press, used unregulated lobby between business groups, which had a less publically obvious impact. In connection with a different policy subsystem, press notes reveal that governmental authorities sought to generate a favourable investment climate and to control potential political conflicts that could resonate in the health reform debate, engaging specifically in activities with business associations, for instance, the Pro-

Growth Agenda[54] to incentivise a collaborative environment. Indeed some comments in the press stated that President Lagos was the favourite president of the business class, as they pursued similar goals and developed informal strategies to reach them. It would be plausible to argue that this collaboration between business groups and the government was also translated to the health policy subsystem, promoting a similar approach to the reform discussion. However, what the research shows is that the process of health reform, even though it was not isolated from negotiations outside the policy subsystem, was embedded in an institutional context very specific to the second phase. The data reveals that, although substantial efforts were made in the first years by coalitions to create alternatives to the reformer plans, the mobilisation of non-governmental advocates was ultimately ineffective. In the second phase, as the context of the Senate narrowed down the space of involvement, the control of the agenda moved to the members of the pragmatic coalition and excluded other participants from the decision-making process.

A second important finding related to resources and strategies was the use of technical knowledge to back up the negotiations and facilitate policy-oriented learning. Other ACF scholars explain that, in a scenario of competition among coalition members, information elaborated by professional experts, because it is seen as based in scientific evidence, provides credibility to beliefs and behaviours (Zafonte and Sabatier 2004; Leifield 2013). It would fair to say then, that the expert knowledge provided by the group of technocrats within the Finance Ministry, as well as legal advisors in the Ministry of Health who built strong ties with researchers from right-wing think tanks, provided synergistic inputs to the learning and negotiation paths. A limitation of the study, that became clear during the analysis of the data, is that the findings do not provide sufficient information to demonstrate that policy learning occurred. This is because there was no substantial transformation of the deep core beliefs, as would be expected according to the ACF, and learning remained at the levels of policy core and secondary aspects.

As noted earlier, the experts that provided technical knowledge to the pragmatic coalition were the advisors to the Ministries of Health and Finance, and researchers from right leaning think tanks. As a general assumption, the successful exploitation of these resources depends on the

[54] See an explanation of these strategies in section 7.2.

capacity of policy makers to convince others that they have the knowledge and information about what the best solution for a policy problem is. In this debate, coalitions were supported by a number of organisations. On the political right, think tanks such as *Libertad y Desarrollo* and *Instituto Libertad* were created in 1990 by people who occupied government positions during the military regime. These formed the intellectual arm that sustained right wing ideas and maintained the legacy of the Pinochet regime in parliamentary work. Some of the advisors from the *Concertación*, also had experience as researchers in think tanks, such as CIEPLAN, CED, and organisations such as CEPAL and PNUD, during the dictatorship. In 1990, they took different positions in the new democratic government.

Respondents mentioned that they incorporation to the governmental team in the Finance Minister was after the decision about the package were decided and indeed an expert says that this idea responded to the guidelines of international organisations. Additionally, much of the policy diffusion of the neoliberal orientations were early adopted in Chile during the 80s. Nonetheless, one of the advisor minister stated that the formula of the Plan AUGE was already designed when she arrived to the team, and they were focus on calculations to make the AUGE economically substaintable, but the model of social rights and guarantees were previously worked by the Sandoval team following guidelines of international organisations as the World Health Organisation and World Bank, which post Washington Consensus where looking to promote more equitable goals. The Lagos's reform was framed in that wave of policy diffusion, with a different emphasis than the reform under the Pinochet's dictatorship.

What is clear is that a critical group of technocrats imposed a work procedure within public organisations, which allowed the collaboration of political advisors in the decision making process. These appointments, of course, also reacted to political interests, as having representation in both formal and informal positions was important, but, in this case, they were able to reach an agreement in order to pass the health reform.

Embracing collaborative and "open to knowledge" behaviour does not necessary ensure policy change. Here, the ACF indicates that particular individuals, policy brokers, may encourage consensus-seeking behaviours from coalition members. Policy brokers are crucial actors that occupy formal positions, have moderate views, and contribute to reducing the polarisation between competitive coalitions (Sotirov and Memmler 2012). Some scholars such as Ingold and Varone (2012), Diaz Kope (2013) and Leifield (2013) stress that ACF case studies have often overlooked

the brokerage role of specific individuals in promoting policy change. In an attempt to fill this gap, this research pays great attention to the role played by policy brokers in the Chilean health reform.

Senators Boeninger and Matthei assumed the role of brokers during the second phase of the reform discussion in Congress. Both senators bolstered the work of the health committee, engaging other senators and advisory teams in the approval of the different components of the reform. They assumed this policy broke role within the committee because of their expertise in political and economic issues, and their reputation within their respective political blocs. The answers of the respondents who were working in the executive suggest that, rather than resulting from a change in their beliefs, the behaviour of the policy brokers was the result of an instrumental view of the process. This stand was adopted because they realised, at that point, that the failure or rejection of the reform would have more electoral costs than benefits. This is similar to the idea of the hurting stalemate described in the first section of this discussion. After all the public battles in 2002 and 2003, it was impossible, particularly for previous members of the neoliberal coalition, to reject the reform. Although some actors from the government recognised that the proposal of the Compensatory Fund was not popular among right-wing politicians, the reform was widely seen as an opportunity for all coalitions to publicly appear as part of the health system improvement process, and to secure votes in the following elections.

The strategic view of the policy brokers in the Chilean reform suggested by the data analysis, challenges previous studies, particularly by those of Sotirov and Memmler (2012) and Arnold (2003), who argue that those who play a brokerage role are neutral or independent from coalition motivations. In particular, Arnold (2003) says that in the Chilean forest subsystem, governmental actors acted as policy brokers in an impartial way. They did not have a particular agenda in the policy regulation discussion, and their participation was limited to managing the debate between private companies and environmentalist organisations. By contrast, this research demonstrates that policy brokers are not disinterested participants and they have political agendas that determine, based on their capacities, coalitions´ trajectories. Senator Matthei and Boeninger were not neutral actors; they exercised leadership within the Senate because they shared the mutual goal of enacting the reform, and developing specific agreements about policy core and secondary instruments.

9.5 POLICY LEGACIES AND COALITIONS' BEHAVIOUR

According review in Chapter 2, institutionalist-based studies of health policies tend to focus on stability and inertia, emphasising institutional arrangements as obstacles for change (Ewig and Kay 2011; Pribble 2013). A number of studies focused on health policy, such as those conducted by Immergut (1990), Guillen (2002), Kaufman and Nelson (2004) and Wong (2006), have used the typology developed by Lijphart (1999), who distinguished democratic systems based on the distribution of power and institutional structures. The aim of this literature is to assess the impact of intervening factors, such as the type of regime (presidentialist versus parliamentarian) or the administrative organisation (federal or centralised), in the health reforms process. Since 2007, with the aim of explaining policy change in different political systems and contexts, Sabatier and Weible (2007) included an institutional component within the ACF. This responded to criticisms that previous studies had paid little attention to subsystems embedded in consensual political systems or systems where political parties dominated the decision-making process (Elliott and Schlaepfer 2001; Ingold and Varone 2012). Recently a number of studies have considered the relevance of formal and informal rules and norms in shaping coalitions (Blank and Burau 2010; Gupta 2013; Fisher 2014; Montefrio 2014) and the findings in this thesis also provide insights for this.

The ACF suggests that institutional arrangements may take the form of stable parameters and/or opportunity structures within the political system. These then frame the interactions of coalitions, and may incite transformation in a particular policy subsystem. As such, this approach integrates one of the premises of the historical institutional perspective, the 'stickiness' of institutions over time (Pierson 1996), into the analysis. This approach has been widely used to analyse Chilean health policy reforms. In the reform that this research analysed, the opportunity structures defined by the policy legacies from the Pinochet dictatorship favoured collaboration between previous opponent coalitions. This facilitated policy change through a negotiated agreement. Specifically, the legacies identified from the data, which framed the evolution of coalitions around the health reform, were political participation, presidential powers, and the electoral system. The findings presented in this section respond the specific question: How did institutional arrangements and policy legacies affect coalition interactions?

The first policy legacy is the degree of political participation inherited from the authoritarian period. As reported in the studies reviewed in Chapter 2, one of the main aspects discussed in the health policy literature is how the end of authoritarian regimes is supposed to augment civil society

participation. This may happen through electoral mechanisms or informal means, giving access to those actors that were excluded, under non-democratic conditions. However, the relationship between democracy and the improvement of civil society participation is complex and not necessarily direct (Kaufman and Nelson 2004). Several studies on health policy reforms in post-authoritarian contexts, such as Kaufman and Nelson (2004), Kwon and Reich (2005) and Wong (2006) recognize the lack of user participation as a feature, due to the concentration of power and repression of citizen participation in former regimes. However, some studies show that democracy enables participation, as in the Spanish case study conducted by Bukowski (2007), where the Constitution enacted after the transition explicitly empowered citizens via legislation, increasing the participation of some actors in the decision-making process. This was reflected in the water policy subsystem, where two new coalitions emerged after the return to the democracy to challenge the dominant coalition.

The findings of this research paint a different picture from the cases reviewed in previous chapters. As the Chilean constitution was conceived and enacted during the period of the Pinochet military government in 1981, it did not include binding mechanisms such as referendums or civil society legal initiatives to protect and to promote formal participation. For instance, the lack of these official procedures in Chile differs from the Spanish experience explained by Bukowski (2007), where new democratic authorities transferred formal prerogatives in decision-making to regional actors, stimulating the involvement of actors at the local level that were previously excluded. While the findings report that there were some participation initiatives in the first stage of the process, such as the roundtables organised by Minister Bachelet in 2001, the data confirms a general lack of substantial citizen involvement. Furthermore, the reformers did not take the views of citizens very seriously. While Bachelet announced, at the beginning of the round tables, that the objective of those meetings was to inclusively define the national health goals, the Ministry of Health, at almost the same time, in January 2002, published a document detailing the national health goals for the decade. That document was developed and signed by specialists and technocrats in a committee organised by the Ministry, making the point that the inclusion of civil society, and their concerns was actually limited and concentrated in a few actors, challenging the expectations of the new democratic governments (Kaufman and Nelson 2004).

It was particularly striking how the *Colegio Medico,* traditionally seen as a powerful group in these processes which would generally refuse any reform affecting their members´ autonomy and salaries, lost power throughout the debate (Immergut 1990; Kaufman and Nelson 2004). This loss

of influence is illustrated by the data gathered from the press and interviews, which corroborates that *Colegio Medico* opposed the reform and fought within the radical coalition against the reformers. In the end, their extreme positions and permanent obstruction of the government's plan resulted in an intentional exclusion of the Colegio from the pragmatic coalition. Additionally, as there was no *Bancada Medica* in the Senate (this is the group of parliamentarian doctors in the Lower Chamber), the power of the medical professions and health workers unions diminished as the formal decision-making process progressed.

Hacker (2004), using the example of the US, has suggested that, as a result of the increase in regulatory systems that restrict their professional autonomy and budget control, there has been a "decline of medical power" in the last decades. This was compounded by the participation of private health companies in managing the provision of services. This situation has some relevance to the privatisation of social policies in Chile during the eighties that consolidated the role of private actors. The reform of 1981, put economic elites in the health market, which then allowed them to become, at the detriment of other actors, key decisions-makers (Gonzalez-Rossetti et al. 2000; Castiglioni 2005; Ewig and Kay 2011; Fairfield 2015).

Furthermore, another aspect, mentioned by the informants and confirmed by the literature, is that the specific characteristics of the health sector accentuate the gap in participation (Bernier and Clavier 2011; Carpenter 2012). The health sector is seen as an extremely technical field where knowledge and expertise are required for decision-making. In addition, the sporadic occurrence of medical events makes people only intermittently aware of the system's deficiencies, as there are few incentives to get involved when they are in good health. It should also be mentioned that Minister Bachelet sent a bill about patients' right and duties to Congress in 2001. However, the congressional debate was postponed for ten years and it did not reach the legislative agenda until the Piñera Administration of 2010-2014. Thus, a bill that was closer to the citizens was not part of this debate during the Lagos period. Although it is not argued that this concentration of power in the elite and the lack of civil society participation was a positive or desirable legacy, the data supports the argument that the progressive exclusion of opponents to the government plan expedited the agreement reached by the pragmatic coalition in the legislative phase.

The second policy legacy identified through the analysis of the data relates to presidential powers and their influence in the health reform process. The findings support arguments that argue that the successful enactment of health reforms depends on the degree of presidential involvement,

as in the Colombian (Ramirez 2004) and South Korea cases (Kwon and Reich 2005; Wong 2006). Data from the Chilean case confirms that this reform was a personal project of President Ricardo Lagos, who was fully committed throughout his mandate, and wanted to be remembered as the first President to make substantial reforms since the return of democracy.[55] Lagos's leadership over the health reform is a distinctive feature of the Chilean processes, differing from other post-authoritarian cases (e.g. Argentina, Brazil, and the Czech Republic), where health reforms emerged from proposals elaborated by public health experts or doctors, rather than being initiated by top-level politicians (Kaufman and Nelson 2004; Roberts 2009).

The findings show that the combination of two factors prompted the enactment of the bill. On the one hand, there were presidential powers granted by the Constitution, particularly, legislative initiative, and the decreeing of urgencies, which allowed the President to control the timing of the legislative agenda. On the other hand, there was the leadership and personality of Ricardo Lagos, who sought to get the reform approved by all means, even by utilising informal strategies. It is worthwhile remembering that President Lagos was extremely devoted to making the health reform a symbol of his government. The formation of coalitions in the first phase responded to the presidential initiative of Lagos. He employed several strategies that allowed him control the reform, though the establishment of a committee to coordinate the inter-ministerial work, led by one of his closest friend, Doctor Hernan Sandoval, stands out. In this way, he could supervise the work of the ministries through Sandoval, controlling the content and timing of the debate. Radical coalition members, in particular, criticised this structure, as it was seen as a dual strategy in the negotiation with other actors, but also as a way to diminish the power of the Ministry of Health. Additionally, President Lagos commanded the Ministry of Finance to join and supervise the debate in all the venues in which the reform was discussed. It is important to recall to one of the informal procedure explained by Siavelis (2016) and mentioned in Chapter 2, which is known as the *"cuoteo"* to distribute the positions in ministries and undersecretaries. For political party leaders, it was important to nominate someone from his or her party heading the key ministries as well as for the

[55] It is worthwhile to mention during his administration there was also passed a Divorce Law in 2004, and in September of 2005, President Lagos enacted a set of amendments to the Constitution of 1981, eliminating most of the Pinochet's authoritarian enclaves. After he signed the modified constitutional text, he declared that the transition was finally over (Funk 2006; Sehnbruch and Siavelis 2014).

president to have someone trustworthy to implement their agendas. As a way to ensure that neither the executive or political parties have the total control of one sector, the *Concertacion* used to designate in as a ministry from one party and an undersecretary, to balance political forces. In health sector, while Bachelet from the Socialist Party (PS) was a Minister, she had as an undersecretary someone from the Christian Democratic Party (PDC) (Ernesto Behnke); and the two consecutive Christian Democrats ministers; Osvaldo Artaza and Pedro Garcia had undersecretaries from the Party for Democracy (PPD).

Several scholars have argued the Chilean Constitution of 1981 gave the president an excessive amount of power through the legislative initiative and control of the urgencies (Siavelis 2000; Aninat et al. 2011; Dockendorff 2011). However, the findings suggest that policy-making depended very much on Congress' decisions, as the health reform needed to be authorised by deputies and senators. This contradicts the independent and excessive power attributed to the Chilean president. As such, most of the struggles between the four initial coalitions took place in the legislative scenario.

The third policy legacy inherited from the dictatorship and commented on by the interviewees, is the implications of the electoral system on health policy reform, and, more generally, on the legislative process and the composition of the Congress. This policy legacy relates specifically to the "opportunity structures" mentioned in the ACF, and the components of openness and degree of consensus needed for change within the political system. On the one hand, electoral mechanisms define who can get access to formal power and how open the system is. On the other hand, they define the "rules of the game" within the legislative branch, which determine the requirements for policy authorisations (who ultimately make the decisions).

As part of the institutional arrangements defined by the 1981 Constitution, the binominal election system[56] used for deputies and senators, and the resulting distribution of seats in Congress, has been "blamed" for the inertia of the Chilean political system. As it is discussed in the literature, electoral mechanisms may enhance or diminish citizens' representation and affect those who can influence the policy-making process. The mechanism for presidential elections

[56] See chapter 2 for details of the Chilean electoral system.

determines its legitimacy and support while the legislative election determines the degree of representation and support for governmental agenda (Siavelis 2000; Swank 2001; Aninat et al. 2011; Dockendorff 2011).

In the Chilean legislative election, the proportional representation system is mainly criticism because the two main electoral pacts, *Concertacion* and *Alianza,* usually get one of their candidates elected in each electoral district of two seats. The same electoral bloc could win both seats only if they got 66.7% of the votes, and therefore the binominal system allows the second list to win a seat even if they get just the 33.4% of the votes. Furthermore, the results of the elections since 1990 have been consistently tied in most districts, dividing the Congress into the electoral pacts from the right and the centre-left. This traditionally excludes candidates from other parties who are not included in the lists of the two main blocs. As such, it is expected that, due to having half of the votes in the legislative branch, the opposition has the possibility to obstruct the legislative agenda of the government. That assumption would be adequate in the fictional scenario where political parties are disciplined, and where politicians have no incentives to cooperate. But in reality, the policy process it is shaped by struggles and bargains among interested and rational actors. The findings reveal that the legislative scenario was not a zero-sum game, instead it was, first, a place of a conflictive debate, and then became a space of collaborative work in the second phase. In fact, the outcomes of the final vote on the AUGE Plan bill in the Senate confirms that although the *Concertación* did not have a majority, they did manage to garner the necessary votes to get most elements of the reform through.

The rules of the game for policy authorisation within Congress played a significant role in funnelling the conflict of coalitions from the Chamber of Deputies to the Senate. As illustrated in the findings chapters, the reformer coalition had a majority in the Lower Chamber, but the discussion and process were highly conflictive due to the opposition of radical and moderate members in the *Concertación*. What is interesting is that, despite the polarised discussion and the debate within the health committee of deputies, the analysis shows that it is possible to argue that the Chamber of Deputies was more a space of debate than of decision-making. Therefore, as it was in the Senate where decisions were made, the Lower Chamber had a limited impact and it was “a ritualistic passage.”

In addition to the electoral system consequences, the implications of “designated senators” were also discussed in Chapter 8 of this thesis. Posing challenges for the centre-left pact, these

senators were traditionally linked with the conservative sectors and the defence of the Pinochet legacies. However, in this case, the data shows that at least two of the designated senators were members of the Christian Democratic Party, and therefore, supported the centre-left government. Specifically, former President Eduardo Frei (a lifelong senator as a former president) and Senator Edgardo Boeninger would give Lagos two secure votes for the health reform package. In the first phase, they were part of rival coalitions, but once the reform reached the Senate, the reformer coalition was able to gain the support of these key actors, and create a single coalition that would guarantee the approval of the bills. As the most relevant discussions took place inside the health committee of the upper chamber, the reformers needed to convince Senator Boeninger, who was one of the members, but was also, initially, an opponent. Additionally, as noted in the interviews, his political leadership and networks were seen as valuable assets for developing a consensus building strategy within the committee. In that way, the findings demonstrate that the institutional arrangements inherited from the authoritarian years were important but not determinant in the outcome of the reform. Ultimately, the results of the Chilean health reform depended on a combination of stable parameters, opportunity structures and coalition configuration and interaction.

Before concluding, it is important to mention another finding about this particular political process. Kaufman and Nelson (2004), in their analysis of health reform processes in Latin America, suggest that their cases confirm that authorities usually negotiate the reforms before sending them to the legislative branch. Similarly, some scholars suggest that Chilean political decision-making is characterised by informal procedures, where political decisions are made "behind the doors" or in a pre-legislative discussion (Dockendorff 2011; Pribble 2013; Gideon 2014). However, the findings of this research challenge this idea, as they show that the negotiation, at least in the Senate, was carried out within the formal institutional context. In this way, this reform was different from other reforms adopted by Chilean governments, which had been decided upon before being submitted for legislative discussion. In this particular case, it was in Congress where policy brokers led a pragmatic advocacy coalition, comprised of senators, members of the health committee and advisors. Based on technical expertise and knowledge, they reached a negotiated agreement to approve the last bill of the health reform in May of 2005.

9.6 FINAL REMARKS

In closing, the purpose of this thesis was to explore how policy change occurred in Chile, a context often characterised by inertia and stability after the return to democracy in 1990. Using the lens of the Advocacy Coalition Framework, the political process of the Chilean health reform during President Ricardo Lagos's administration (2000-2006) was analysed, looking specifically at the factors that enabled the policy change. Although a number of studies have examined health policy reforms in Chile, generally based on an historical institutional approach that emphasise the immobility of the Chilean political system due to the institutional arrangements inherited from the authoritarian period; there has not been strong focus on how despite this context, new policies are put into place. As such, this study contributes to this literature by arguing that policy change did occur, as demonstrated by the health policy reform approved in 2005.

In doing so, this thesis draws strongly on the Advocacy Coalition Framework for examining this case, where policy change could not be explained by the occurrence of external events or exogenous shocks in the national context. The main aim of the ACF is to provide a theoretical explanation of policy change by looking at advocacy coalitions within a particular subsystem, that shares beliefs and acts in a non-trivial manner to influence the decision-making processes (Sabatier and Jenkins-Smith 1993; Jenkins-Smith et al. 2014). The findings of this study provide an example of how one of the paths pointed out by the ACF, the negotiated agreement, can explain policy change in the Chilean health subsystem.

As discussed in this chapter, a number of factors were crucial for reaching an agreement and facilitating policy change. First, the evolution of the coalition structure, which moved from a competitive scenario of four coalitions, into a collaborative situation in which one coalition pursued a consensus-building strategy. Second, advocate groups used formal and informal resources and strategies, such as the provision of expert support and the presence of policy brokers that had political will to pass the bill, strengthening the position of the pragmatic coalition. An additional conclusion of this thesis is that policy legacies from the authoritarian years were important, as they provided the framework for interplay of coalitions, but they did not constrain health policy change.

9.6.1 Contributions

This thesis contributes to discussions about policy change and the expansion of the ACF in several ways. First, using Chile as a case study permits the expansion of the theoretical knowledge of the ACF as little research has been done regarding negotiated agreement in the literature so far. Perhaps, as it was one of the latest elements elaborated by the ACF main authors, this is not surprising (Sabatier and Weible 2007; Jenkins-Smith et al. 2014). Furthermore, a the dynamic view of the configuration of coalitions over time is also a contribution of this research, as generally studies applying the ACF show that coalitions are more stable than changing. Additionally, this thesis enriches the understanding of the resources and strategies employed by coalitions, including the role played by policy brokers to deescalate potential conflicts and to stimulate a collaborative relationship. Another contribution is the analysis of the institutional arrangements that provides insights for examining the opportunity structures identified by the ACF, which have been overlooked until recently. This thesis, considering the policy legacies from the authoritarian period, unpacks how these factors affected the process of health policy reform in Chile. Based on this analysis, this thesis challenges the widely accepted argument of institutionalist scholars that suggests that the lack of structural reforms in Chile is the result of the heaviness of the legacies inherited from the dictatorship of Augusto Pinochet (1973-1990). As demonstrated, the policy legacies framed the policy process but did not define the outcomes of it. Lastly, this research has also made an empirical contribution to decision-making. As a retrospective analysis, the results may shed light on the complexities of the process, generating knowledge on who the key actors were and factors that determine the feasibility of reforms in post-authoritarian countries. This may help policy makers in designing future public policies.

9.6.2 Limitations

In terms of limitations, as this study investigated the perceptions of elites, there is a lack of opinions from other segments of the population that were affected by the reform, such as users,

NGOs, or community representatives[57]. Additionally, as the interviews were used to capture the perceptions and meanings of people involved in the process, the fact that some persons were inaccessible, such as Senators Boeninger and Matthei, means the picture of the process is incomplete. Related with the inaccessibility of some key actors, the timeframe of the second part of my fieldwork affected the possibility of getting more interviews, as it was in the last two months of the presidential and congressional electoral campaign.

A methodological limitation of this research is related to the identification of beliefs as, unfortunately, the nature of the data (it was not part of the topic guide), did not allow the researcher to determine whether there was transformation in the beliefs system of coalition members. The lack of explanation of beliefs means that there cannot be certainty into what extent the policy change was motivated by a real modification of individuals understanding about the health sector.

9.6.3 Further research

Some recommendation can be made for future research. Further studies should incorporate an analysis of the implementation phase at the meso and micro levels, to evaluate the empirical consequences of the design and formulation of policies. This could provide a long-term perspective of the policy process. Linked to one of the limitations of the study mentioned above, the inclusion of other actors from the civil society and their perceptions about the impact of the reform would be also useful.

A comparison of policy subsystems in various countries would also be useful, as it would definitely increase our understanding of the implications of different institutional arrangements in dissimilar settings. In the same vein, comparative studies of different policy subsystems within the same country may provide interesting results regarding the existence coalitions under the same political system. Future works could also benefit from including other methodological techniques for the identification of coalitions. Specifically, social network analysis could enrich the

[57] Even though the findings demonstrate they were not part of the decision-making, this is still an important limitation to note.

identification of actors, their connections, and the strengths or weaknesses of their beliefs systems.

Finally, a topic that emerged after the health reform in Chile and therefore has not been considered in this analysis is the "judicialisation of health". The new regulatory framework of 2005 increased governmental control of ISAPRES, and guaranteed access to healthcare for specified conditions. This has empowered private sector users to make complaints and to sue these companies in courts, with claims about the change in prices, or breach of health contracts. This legal controversy is an issue that gauges the levels of civil society participation and therefore, could be explored in-depth as part of the consequences of this reform.

BIBLIOGRAPHY

Abrar, S., J. Lovenduski, and H. Margetts. 2000. “Feminist Ideas and Domestic Violence Policy Change.” *Political Studies* 48 (2): 239–62.

Adam, S. and H. Kriesi. 2007.”The Network Approach”. In: *Theories of the Policy Process*. Sabatier, P (Ed). 2nd ed. Boulder, Colorado: Westview Press.

Aguilera, X., C. Castillo-Laborde, M. Nájera-De Ferrari, I. Delgado, and C. Ibañez. 2014. “Monitoring and Evaluating Progress towards Universal Health Coverage in Chile.” *PLoS Medicine* 11 (9): e1001676.

Albright, E. A. 2011. “Policy Change and Learning in Response to Extreme Flood Events in Hungary: An Advocacy Coalition Approach: Albright: Policy Change and Learning.” *Policy Studies Journal* 39 (3): 485–511.

Allison, G. 1971. Essence of Decision: Explaining the Cuban Missile Crisis. Boston: Little, Brown and Company.

Angell, A. 2007. *Democracy after Pinochet: Politics, Parties and Elections in Chile*. London: Institute for the Study of the Americas.

Aninat, C. 2006. “Balance de poderes legislativos en Chile. ¿Presidencialismo exagerado o base de un sistema político cooperativo?” *Revista de Ciencia Política*, 23 (2): 43-67

Aninat, C., J. Londregan, J., P. Navia, and J. Vial. 2011. “Juego político cooperativo. Instituciones, procesos políticos, y características de las políticas públicas en Chile”. En: El juego político en América Latina: *¿Cómo se deciden las políticas públicas?.* Scartascini, C., P. Spiller, E. Stein y M. Tommasi, editores. BID, Colombia.

Arksey, H., and P. Knight. 1999. *Interviewing For Social Scientists*. London: Sage Publications.

Arnold, F.E. 2003. “Native Forest Policy in Chile: Understanding Sectoral Process Dynamics in a Country with an Emerging Economy.” *International Forestry Review* 5 (4): 317–28.

Arrau, F. 2000. Conceptualización del plan de acceso universal con garantías explícitas (AUGE), eje de la actual reforma a la salud. Valparaíso: Biblioteca del Congreso Nacional de Chile.

Arretche, M. 2004. “Toward a Unified and More Equitable System: Health Reform in Brazil”. In: *Crucial Needs, Weak Incentives: Social Sector Reform, Democratization, and Globalization in Latin America*. Kaufman, R. and Nelson, J. (Eds.). Washington, D.C. : Baltimore: Woodrow Wilson Center Press; Johns Hopkins University Press.

Arza, C. and M. Kohli. 2007. Pension Reform in Europe: Politics, policies and outcomes. London: Routledge.

Aspinall, E. 2014. “Health Care and Democratization in Indonesia.” *Democratization* 21 (5): 803–23.

Bachrach, P. and M. Baratz. 1962. "Two Faces of power". *American Political Science Review*, Vol.56, No.4

Baeza, J. 2005. Restructuring the Medical Profession: The Intraprofessional Relations of GPs and Hospital Consultants. Buckingham: Open University Press.

Barbazza, E., and J. E. Tello. 2014. “A Review of Health Governance: Definitions, Dimensions and Tools to Govern.” *Health Policy* 116 (1): 1–11.

Barker, C. 1996. *The Health Care Policy Process*. London: SAGE.

Barrientos, A. 2002. “Health Policy in Chile: The Return of the Public Sector?” *Bulletin of Latin American Research* 21 (3): 442–59.

Bastias, G., T. Pantoja, T. Leisewitz, and V. Zarate. 2008. “Health Care Reform in Chile.” *Canadian Medical Association Journal* 179 (12): 1289–92.

Baumgartner, Frank R., and Bryan D. Jones. 1993. *Agendas and Instability in American Politics*. American

Politics and Political Economy Series. Chicago: University of Chicago Press.
Baumgartner, F. R. 2014. “Ideas, Paradigms and Confusions.” *Journal of European Public Policy* 21 (3): 475–80.
Beland D. 2010. “Policy Change and Health Care Research,” *Journal of Health Politics, Policy and Law* 35(4): 607-633.
Bellisario, A. 2007. “The Chilean Agrarian Transformation: Agrarian Reform and Capitalist ‘Partial’ Counter-Agrarian Reform, 1964-1980. Part 1: Reformism, Socialism and Free-Market Neoliberalism.” *Journal of Agrarian Change* 7 (1): 1–34.
Benavides, C., M. I. Errázuriz, D. Kimber, I. Santa María, and A. Van Weezel. 2009. “The Chilean Media Landscape”. In: *The Handbook Of Spanish Language Media*. Albarran, A. 2009. New York: Routledge.
Berman, P., and T. Bossert. 2000. “A Decade of Health Sector Reform in Developing Countries: What have we learn?”. Data for Decision Making Project, International Health Systems Group, Harvard School of Public Health.
Bernard, H. R., and G. W. Ryan. 2010. *Analyzing Qualitative Data*. Los Angeles: SAGE.
Bernier, N. F., and C. Clavier. 2011. “Public Health Policy Research: Making the Case for a Political Science Approach.” *Health Promotion International* 26 (1): 109–16.
Bitrán, R. and L. Escobar. 2008. *The Politics of the AUGE Health Reform in Chile*. Case Study prepared for the Results for Development Institute. Available in: http://www.resultsfordevelopment.org/products/politics-auge-health-reform-chile-case-study.
Blank, R. H., and V. D. Burau. 2010. *Comparative Health Policy*. 3rd ed. Basingstoke, Hampshire: New York: Palgrave Macmillan.
Boeninger, E. 2005. “Economia Politica de la Reforma de la Salud”. En: *Reforma de Salud en Chile: Desafios de la Implementación.* Sanchez, H. and Labbe (eds.). Santiago de Chile: Universidad Andrés Bello.
Bonoli, G. 2001. “Political institutions, veto points, and the process of welfare state adaptation”. In: *The New Politics of the Welfare State*. Pierson, P., (Ed.). Oxford: Oxford University Press.
Borzutzky, S. and L. Oppenheim (Eds). 2006. After Pinochet: The Chilean Road to Democracy and the Market. Gainesville, FL: University Press of Florida.
Bossert, T. J. 2012. “Health Systems.” *Health Policy and Planning* 27 (1): 8–10.
Bowling, A. 2002. *Research Methods in Health: Investigating Health and Health Services*. 2nd ed. Buckingham ; Philadelphia: Open University Press.
Braithwaite, J., Y. Matsuyama, R. Mannion, and J. K. Johnson (Eds.). 2015. *Healthcare Reform, Quality and Safety: Perspectives, Participants, Partnerships, and Prospects in 30 Countries*. Farnham, Surrey, England ; Burlington, VT: Ashgate Publishing Limited.
Braun, V., and V. Clarke. 2006. “Using Thematic Analysis in Psychology.” *Qualitative Research in Psychology* 3 (2): 77–101.
Breton E. and E. De Leeuw. 2011. “Theories of the policy process in health promotion research: a review”. *Health Promotion International* 26: 82–90.
Bresser Pereira, C. et al. 1993. *Economic Reforms in New Democracies: A Social-Democratic.* Cambridge University Press.
Bryant, T. 2002. “Role of Knowledge in Public Health and Health Promotion Policy Change.” *Health Promotion International* 17 (1): 89–98..
Bryman, A. 2012. *Social Research Methods*. Oxford: Oxford University Press.
Bukowski, J. 2007. “Spanish Water Policy and the National Hydrological Plan: An Advocacy Coalition Approach to Policy Change.” *South European Society and Politics* 12 (1): 39–57.

Bunce, V. 1995. “Comparing East and South.” *Journal of Democracy* 6 (3): 87–100.
Burau, V. 2012. “Transforming Health Policy and Services: Challenges for Comparative Research.” *Current Sociology* 60 (4): 569–78.
Bureau, V., R. Blank, and E, Pavolini. 2015. “Typologies of healthcare System and Policies”. In: *The Palgrave International Handbook of Healthcare Policy and Governance*. Kuhlmann, E., R. Blank, I. Bourgeault, and C. Wendt (Eds.). Palgrave Handbooks. Houndsmills, Basingstoke, Hampshire ; New York, NY: Palgrave Macmillan.
Buse, K., N. Mays, and G. Walt. 2005. *Making Health Policy*. Maidenhead: Open University Press.
Bustamante, A. V., and C. A. Mendez. 2014. “Health Care Privatization in Latin America: Comparing Divergent Privatization Approaches in Chile, Colombia, and Mexico.” *Journal of Health Politics, Policy and Law* 39 (4): 841–86.
Cabezas, J.M. and P. Navia. 2005. "Efecto del sistema binominal en el número de candidatos y de partidos en elecciones legislativas en Chile, 1989-2001". *Política*, 45, 29-51.
Cairney, P. 2009. “The Role of Ideas in Policy Transfer: The Case of UK Smoking Bans since Devolution.” *Journal of European Public Policy* 16 (3): 471–88.
———. 2012. *Understanding Public Policy: Theories and Issues*. Houndmills, Basingstoke, Hampshire ; New York: Palgrave Macmillan.
Cairney, P., and T. Heikkila 2014. “A Comparison of Theories of the Policy Process.” In *Theories of the Policy Process*. Boulder, CO: Westview Press, a member of the Persus Books Group.
Cairney, P. and C. M. Weible. 2015. “Comparing and Contrasting Peter Hall’s Paradigms and Ideas with the Advocacy Coalition Framework”. In: *Policy Paradigms in Theory and Practice: Discourses, Ideas and Anomalies in Public Policy Dynamics*. Hogan, J., and M. Howlett. Basingstoke: Palgrave Macmillan.
Carbone, G. 2012. “Do New Democracies Deliver Social Welfare? Political Regimes and Health Policy in Ghana and Cameroon.” *Democratization* 19 (2): 157–83.
Carboni, N. 2012. “Advocacy and Policy Change in the Multilevel System of the European Union: A Case Study within Health Policy.” *Open Journal of Political Science* 02 (03): 32–44.
Carpenter, D. 2012. “Is Health Politics Different?” *Annual Review of Political Science* 15 (1): 287–311.
Carvalho, G. O. 2001. “Metallurgical Development in the Caraja´s Area: A Case Study of the Evolution of Environmental Policy Formation in Brazil.” *Society & Natural Resources* 14 (2): 127–43.
Castiglioni, R. 2005. The Politics of Social Policy Change in Chile and Uruguay: Retrenchment versus Maintenance, 1973-1998. New York: Routledge.
———. 2006. "Cambios y continuidad en política social: educación, pensiones y salud." En: *El Gobierno de Ricardo Lagos. La nueva vía chilena hacia al socialismo*. Funk, R. (ed.). 2006. Santiago de Chile: Ediciones UDP.
Celedón, C., and C. Oyarzo. 1999. “Hacia una nueva garantía universal en la salud: una nueva relación entre lo público y lo privado.” En *El Estado y el sector privado*. Muñoz, O. 1999. Santiago de Chile: Dolmen y FLACSO Chile.
Cereceda, L. and L. Hoffmeister. 2008. “La reforma de salud en Chile: cambios institucionales, logros y dificultades en su implementacion.” Working paper N°1149, Center of Migration and Development, Princeton University. Available on: http://www.princeton.edu/cmd/working-papers/idlac08/wp0805e.pdf.
Chaqués, L., and A. Palau. 2009. “Comparing the Dynamics of Change in Food Safety and Pharmaceutical Policy in Spain.” *Journal of Public Policy* 29 (01): 103.
Cid, C. 2008. “Causas estructurales de los problemas de inequidad en el acceso a la salud en Chile.” R*evista Chilena de Salud Pública*, 12 (2).

Collins, C., A. Green, and D. Hunter. 1999. “Health Sector Reform and the Interpretation of Policy Context.” *Health Policy* 47 (1): 69–83.

Collins, C. 2014 “Human Rights Policy under the Concertación”. In: *Democratic Chile: The Politics and Policies of a Historic Coalition, 1990–2010.* Siavelis, P. and K. Sehnbruch (eds). Boulder, CO: Lynne Rienner.

Conti, J. A., and M. O’Neil. 2007. “Studying Power: Qualitative Methods and the Global Elite.” *Qualitative Research* 7 (1): 63–82.

Contreras, D. and K. Sehnbruh. 2014.“Social Policies: From Social Debt to Welfare State?”. In: *Democratic Chile: The Politics and Policies of a Historic Coalition, 1990–2010.* Siavelis, P. and K. Sehnbruch (eds). Boulder, CO: Lynne Rienner Publishers.

Cook, L. J. 2007. Postcommunist Welfare States: Reform Politics in Russia and Eastern Europe. Ithaca: Cornell University Press.

Cortes Terzi, A. 2000. El circulo extrainstitucional del poder. Santiago, EdicionesChile America CESOC.

Cotlear, D., O. Gómez-Dantés, F. Knaul, R. Atun, I. C H C Barreto, O. Cetrángolo, M. Cueto. 2015. “Overcoming Social Segregation in Health Care in Latin America.” *The Lancet* 385 (9974): 1248–59.

Cousins, M. 2005. European Welfare States: Comparative Perspectives. London: SAGE Publications.

Crinson,I. 2009. *Health Policy: A Critical Perspective*. London: Sage Publications

Dahl, R. 1957. "The Concept of Power." *Behavioral Science* 2 (3): 201

Dannreuther, C., and J. Gideon. 2008. “Entitled to Health? Social Protection in Chile’s Plan AUGE: Social Protection in Health: Chile’s Plan AUGE.” *Development and Change* 39 (5): 845–64

Dargent, E. 2012. “Technocracy under democracy: assessing the political autonomy of experts in Latin America”. PhD. Dissertation, The University of Texas at Austin

Dávila, M., and C. Fuentes. 2003. *Promesas De Cambio*. Santiago de Chile: FLACSO-Chile.

Dávila, M. 2005. “Health Reform in Contemporary Chile: Does Politics Matter?” Master Thesis, UNC North Carolina.

Della Porta, D., and M. Keating (Eds.). 2008. *Approaches and Methodologies in the Social Sciences: A Pluralist Perspective*. Cambridge: Cambridge University Press.

Denzin, N. K., and Y. S. Lincoln. 2011. *The Sage Handbook Of Qualitative Research*. Thousand Oaks: Sage.

Diaz-Kope, L., J. Lombard, and K. Miller-Stevens. 2013. “A Shift in Federal Policy Regulation of the Automobile Industry: Policy Brokers and the ACF.” *Politics & Policy* 41 (4): 563–87.

Dides, C. 2006. Voces En Emergencia: El Discurso Conservador Y La Píldora Del Día Después. Santiago de Chile: FLACSO-Chile : UNFPA.

Dockendorff, A. 2011. “El rol del congreso en la formulación de la política de modernización de la gestión pública”. En:*¿Cómo Se Formulan Las Políticas Públicas En Chile?* Olavarría, M. (Ed.). Santiago de Chile: Editorial Universitaria.

Drago, M., and UN. ECLAC. Social Development Division. 2006. *La reforma al sistema de salud chileno desde la perspectiva de los derechos humanos*. Santiago de Chile: Naciones Unidas, CEPAL, División de Desarrollo Social.

Drake, P. W., and I. Jaksic (Eds). 1999. *El Modelo Chileno: Democracia Y Desarrollo En Los Noventa*. Santiago de Chile: LOM Ediciones.

Duke, K. 2002. “Getting Beyond the ‘Official Line’: Reflections on Dilemmas of Access, Knowledge and Power in Researching Policy Networks.” *Journal of Social Policy* 31 (01).

Ehrlich, S. D. 2011. *Access Points*. New York: Oxford University Press.

Elaqua, G., and P. Gonzalez. 2014. “Education: Freedom of Choice or Enterprise?”. In: *Democratic Chile:*

The Politics and Policies of a Historic Coalition, 1990–2010. Siavelis, P. and Sehnbruch, K. (eds). Boulder, CO: Lynne Rienner Publishers.

El Ladrillo. 1973. Bases de la Política Económica del Gobierno Militar. Available inhttp://www.memoriachilena.cl/temas/documento_detalle.asp?id=MC0032306.

Elliott, C. and R. Schlaepfer. 2001. "Understanding Forest Certification Using the Advocacy Coalition Framework." *Forest Policy and Economics* 2 (3-4): 257–66.

Erazo, A. 2011. "La protección social en Chile El Plan AUGE: Avances y desafíos". *Serie Financiamiento del desarrollo.* Santiago de Chile: CEPAL. N° 238

Esping-Andersen, G. 1990. *The Three Worlds of Welfare Capitalism*. Cambridge: Cambridge University Press.

———. 1996. "After the Golden Age? Welfare State Dilemmas in a Global Economy." In: *Welfare States in Transition: National Adaptations in Global Economies.* G. Esping-Andersen (ed.). London: Sage Publications.

Espinoza, V. 2010. "Redes de poder y sociabilidad en la elite politica chilena. Los parlamentarios 1990-2005". *Polis, Revista de la Universidad Bolivariana*, no 9 (26)

Ewig, C., and S. J. Kay. 2011. "Postretrenchment Politics: Policy Feedback in Chile's Health and Pension Reforms." *Latin American Politics and Society* 53 (4): 67–99.

Ewig, C., and G. A. Palmucci. 2012. "Inequality and the Politics of Social Policy Implementation: Gender, Age and Chile's 2004 Health Reforms." *World Development* 40 (12): 2490–2504..

Fairfield, T. 2015. Private Wealth and Public Revenue in Latin America: Business Power and Tax Politics. New York: Cambridge University Press.

Falleti, G. 2010. "Infiltrating the State: The Evolution of Health Care Reforms in Brazil, 1964-1988": In: *Explaining Institutional Change: Ambiguity, Agency, and Power*. Mahoney, J. and K. Thelen. (Eds.). New York: Cambridge University Press.

Ferrer, M. 2004. "Plan Auge y Reforma a la Salud: ¿Vía a la equidad en salud?". *Agenda Pública.* Año III, N° 4 Universidad de Chile.

Fischer, M. 2014. "Coalition Structures and Policy Change in a Consensus Democracy: Coalition Structures and Policy Change." *Policy Studies Journal* 42 (3): 344–66.

Flores-Macias, G. 2012. *After Neoliberalism?: The Left and Economic Reforms in Latin America*. Oxford ; New York: Oxford University Press.

Flyvbjerg, B. 2006. "Five Misunderstandings About Case-Study Research." *Qualitative Inquiry* 12 (2): 219–45.

Freeman, R. 2000. *The politics of health in Europe*. Manchester: Manchester University Press.

Frenk, J. 1990. "The Political Economy of Medical Underemployment in Mexico: Corporatism, Economic Crisis and Reform." *Health Policy* 15 (2–3): 143–62.

———. 1994. "Dimensions of Health System Reform." *Health Policy* 27 (1): 19–34.

———. 1995. "Comprehensive Policy Analysis for Health System Reform." *Health Policy* 32 (1–3): 257–77.

Freigedo, M., G. Fuentes, and M. Rodríguez. 2015. "Construyendo una coalición Para romper el paisaje congelado: alcances y límites de la reforma de la salud en Uruguay (2005-2014)." *Íconos - Revista de Ciencias Sociales* 19 (53): 49.

Frenz, P., I. Delgado, J. S. Kaufman, and S. Harper. 2014. "Achieving Effective Universal Health Coverage with Equity: Evidence from Chile." *Health Policy and Planning* 29 (6): 717–31.

Fuentes, C. (Ed.). 2010. En *Nombre del Pueblo. Debate sobre el cambio constitucional en Chile*. Santiago de Chile: Fundación Boell y Universidad Diego Portales

———. 2012. El Pacto: Poder, Constitución y Prácticas políticas en Chile 1990-2010. Santiago de Chile:

Ediciones Universidad Diego Portales
———. 2013. El Fraude: crónica sobre el plebiscito de la constitución de 1980. 1. ed. Santiago de Chile: Ed. Hueders.
Funk, R. 2004. "Renovation and Continuity: The Transition to Democracy in Chile Revised". PhD Thesis. London School of Economics.
———. (Ed.). 2006. *El Gobierno de Ricardo Lagos: La Nueva Vía Chilena Hacia El Socialismo*. Colección Ciencias Sociales E Historia. Santiago de Chile: Ediciones Universidad Diego Portales.
Gagnon, F., J. Turgeon, and C. Dallaire. 2007. "Healthy Public Policy." *Health Policy* 81 (1): 42–55.
Garreton, M. A. 1995. Redemocratization in Chile*. Journal of Democracy* Vol 6, Number 1, January.
———.2003. *Incomplete Democracy: Political Democratization in Chile and Latin America*. Latin America in Translation. Chapel Hill: University of North Carolina Press.
Garretón, M., and R.Garretón. 2010. "La Democracia Incompleta En Chile: La Realidad Tras Los Rankings Internacionales." *Revista de Ciencia Política* 30 (1)
Gerring, J. 2004. "What Is a Case Study and What Is It Good For?" *American Political Science Review* 98 (02).
Giaimo, S., and P. Manow. 1999. "Adapting the Welfare State: The Case of Health Care Reform in Britain, Germany, and the United States." *Comparative Political Studies* 32 (8): 967–1000.
Gideon, J. 2005. "Consultation or Co-option? A Case Study from the Chilean Health Sector". *Progress in Development Studies* 5(3): 169–81.
Gideon, J. 2006. "Integrating Gender Issues into Health Policy". *Development and Change* 37(2): 329–52.
Gideon, J. 2007. "Excluded from Health? Informal Workers' Access to Health Care in Chile". *Bulletin of Latin American Research* 26(2): 238–55.
Gideon, J. 2014. *Gender, Globalization, and Health in a Latin American Context*. Studies of the Americas. New York, NY: Palgrave Macmillan.
Gideon, J. and G. Alvarez. 2016. "Institutional Constraints to Engendering the Health Sector in Bachelet's Chile". In: *Gender, institutions, and change in Bachelet's Chile.* Waylen, G. (Ed.). New York City: Palgrave Macmillan.
Gillham, B. 2005. *Case Study Research Methods*. Real World Research. London: Continuum.
Gilson, L. 2012. *Health Policy And Systems Research*. Geneva, Switzerland: Alliance for Health Policy and Systems Research.
Giovanella, L. and M. Faria. 2015. "Health Policy Reform in South America". In: *The Palgrave International Handbook of Healthcare Policy and Governance*. Kuhlmann, E., R. Blank, I. Bourgeault, and C. Wendt (Eds.). Palgrave Handbooks. Houndsmills, Basingstoke, Hampshire ; New York, NY: Palgrave Macmillan.
Gomm, R., M. Hammersley, and P. Foster (Eds.). 2000. *Case Study Method: Key Issues, Key Texts*. London: SAGE Publications.
Gonzalez-Rossetti, A. and T. Bossert. 1999. Comparative Analysis of Policy Processes: Enhancing the Political Feasibility of Health Reform. Chile, Colombia and Mexico. Data for Decision Making (DDM). U.S. Agency for International Development.
Gonzalez-Rossetti, A., T. Chuaqui, and C. Espinosa. 2000. *Enhancing the Political Feasibility of Health Reform: The Chile Case Chile.* Cambridge, MA: Harvard School of Public Health and Latin America and the Caribbean Regional Health Sector Reform Initiative.
Gonzalez-Rossetti, A. 2001. "The Political Dimension of Health Reform: The Case of Mexico and Colombia". PhD Thesis, University of London.
Gormley, W. T. 2007. "Public Policy Analysis: Ideas and Impacts." *Annual Review of Political Science* 10 (1): 297–313.

Greer, S. L., and D. F. Lillvis. 2014. “Beyond Leadership: Political Strategies for Coordination in Health Policies.” *Health Policy* 116 (1): 12–17.

Grindle, M. and J. Thomas. 1991. Public Choices and Policy Change: The Political Economy of Reform in Developing Countries. Baltimore, MD: Johns Hopkins University Press.

Grindle, M. S. 2004. “Good Enough Governance: Poverty Reduction and Reform in Developing Countries.” *Governance* 17 (4): 525–48.

Grix, J. 2002. “Introducing Students to the Generic Terminology of Social Research.” *Politics* 22 (3): 175–86.

Gronemeyer, M. E., and W. Porath. 2015. “A Study on Homogeneity between Editorials and News Sources Opinions in the Chilean Reference Press.” *Cuadernos.info* 36 (April): 139–53.

Gubrium, J. F., and J. Holstein. 2002. *Handbook of Interview Research: Context and Method.* Thousand Oaks, CA: Sage

Guillen, A. M. 2002. “The Politics of Universalisation: Establishing National Health Services in Southern Europe.” *West European Politics* 25 (4): 49–68.

Guldbrandsson, K., and B. Fossum. 2009. “An Exploration of the Theoretical Concepts Policy Windows and Policy Entrepreneurs at the Swedish Public Health Arena.” *Health Promotion International* 24 (4): 434–44.

Gupta, K. 2013. “Order in a Chaotic Subsystem: A Comparative Analysis of Nuclear Facility Siting Using Coalition Opportunity Structures and the Advocacy Coalition Framework.” PhD. Thesis, University of Oklahoma.

———. 2014. “A Comparative Policy Analysis of Coalition Strategies: Case Studies of Nuclear Energy and Forest Management in India.” J*ournal of Comparative Policy Analysis: Research and Practice* 16 (4): 356–72.

Hacker, J. 1998. “The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy”. *Studies in American Political Development*, 12, pp 57-130.

———. 2002. The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States. Cambridge: Cambridge University Press.

———. 2004. “Review Article: Dismantling the Health Care State? Political Institutions, Public Policies and the Comparative Politics of Health Reform.” *British Journal of Political Science* 34 (4): 693–724.

———. 2010. “The Road to Somewhere: Why Health Reform Happened.” *Perspectives on Politics* 8 (03): 861–76.

Haggard, S., and R. Kaufman. 2008. Development, Democracy, and Welfare States: Latin America, East Asia, and Eastern Europe. Princeton: Princeton University Press.

Hall, P. A. 1993. “Policy Paradigms, Social Learning, and the State: The Case of Economic Policymaking in Britain.” *Comparative Politics* 25 (3): 275.

Hall, P. A., and R. C. R. Taylor. 1996. “Political Science and the Three New Institutionalisms.” *Political Studies* 44 (5): 936–57.

Halperin, S., and O. Heath. 2012. *Political research: Methods and practical skills*. Oxford: Oxford University Press.

Han, H., B. Swedlow, and D. Unger. 2014. “Policy Advocacy Coalitions as Causes of Policy Change in China? Analyzing Evidence from Contemporary Environmental Politics.” *Journal of Comparative Policy Analysis: Research and Practice* 16 (4): 313–34.

Haeder, S. F. 2012. Beyond Path Dependence: Explaining Healthcare Reform and Its Consequences. *Policy Studies Journal* 40: 65–86.

Harvey, W. S. 2011. “Strategies for Conducting Elite Interviews.” *Qualitative Research* 11 (4): 431–41.

Harrinkari, T., P Katila, and H. Karppinen. 2016. “Stakeholder Coalitions in Forest Politics: Revision of Finnish Forest Act.” *Forest Policy and Economics* 67: 30–37.

Hassenteufel, P. and B. Palier. 2008. “Towards Neo-Bismarckian Health Care States? Comparing Health Insurance Reforms in Bismarckian Welfare Systems”. In: *Reforming the Bismarckian Welfare Systems*. Broadening Perspectives on Social Policy. Palier, B. and C. Martin (Eds.). Malden, MA ; Oxford: Blackwell Pub.

Häusermann, S. 2010. The politics of Welfare State reform in Continental Europe. Modernization in hard times. Cambridge: Cambridge University Press.

Hay, C. 2002. *Political Analysis*. A Critical Introduction, Basingstoke: Palgrave.

Heclo, H. 1974. Modern Social Politics in Britain and Sweden: From Relief to Income Maintenance. New Haven: Yale University Press.

Henry, A. D. 2011. “Ideology, Power, and the Structure of Policy Networks.” *Policy Studies Journal* 39 (3): 361–83.

Hicken A., and J. S. Selway. 2012. “Forcing the genie back in the bottle: sociological change, institutional reform, and health policy in Thailand”. *Journal of East Asian Studies* 12(1):57-88.

Hicks, A. M., and D.Swank. 1992. “Politics, Institutions, and Welfare Spending in Industrialized Democracies, 1960-82.” *The American Political Science Review* 86 (3): 658.

Hogan, J., and M. Howlett. 2015. Policy Paradigms in Theory and Practice: Discourses, Ideas and Anomalies in Public Policy Dynamics. Basingstoke: Palgrave Macmillan.

Howlett, M. 2011. *Designing Public Policies: Principles and Instruments*. Routledge Textbooks in Policy Studies. Abingdon, Oxon ; New York: Routledge.

Huber, E., and J. D. Stephens. 2001. *Development and Crisis of the Welfare State: Parties and Policies in Global Markets*. Chicago/London: University of Chicago Press.

Huber, E., and J. D. Stephens. 2012. *Democracy and the Left: Social Policy and Inequality in Latin America*. Chicago: University of Chicago Press.

Huber, E., C. Ragin, and J. D. Stephens. 1993. “Social Democracy, Christian Democracy, Constitutional Structure, and the Welfare State.” *American Journal of Sociology* 99 (3): 711.

Hunneus, C. 2000. *The Pinochet Regime*. Santiago de Chile: Editorial Sudamericana

Illanes, M. and M. Riesco. 2007. “Developmentalism and social change in Chile”. In: *Latin America: A New Developmental Welfare State Model in the Making?*. Riesco, M. (ed). Social Policy in a Development Context. Basingstoke; New York: Palgrave Macmillan/UNRISD.

Imbeau, L. M., F. Petry, and M. Lamari. 2001. “Left-Right Party Ideology and Government Policies: A Meta-Analysis.” *European Journal of Political Research* 40 (1): 1–29.

Immergut, E. M. 1990. “Institutions, Veto Points, and Policy Results: A Comparative Analysis of Health Care.” *Journal of Public Policy* 10 (04): 391.

Immergut, E. M. 1992. *Health Politics: Interests and Institutions in Western Europe*. Cambridge: Cambridge University Press.

Immergut, E. M. 2006. “Institutional Constraints on Policy”. In: *The Oxford Handbook Of Public Policy*. Moran, M., M. Rein, and R. E. Goodin. Oxford: Oxford University Press.

Immergut, E. M. 2010. "The Politics of the Obama Health Reform, or, It’s the Veto Points!" *States, Power, and Societies*. Newsletter of the Political Sociology Section of the American Sociological Association, 15(2): 2,5,7.

Immergut, E. M. 2010. ”Political Institutions". In: *The Oxford Handbook of The Welfare State*. Castles, F.G., S. Leibfried, J. Lewis, H. Obinger, and C. Pierson (Eds.) Oxford: Oxford University Press.

Immergut, E. and T. Abou-Chadi. 2010. *Political and Institutional Determinants of Social Legislation. The Role of Veto Points, Veto Players, and Electoral Pressure.* BGSS Working Paper No. 3, Department

of Social Sciences, Humboldt-Universität zu Berlin.
Ingold, K., and F. Varone. 2012. "Treating Policy Brokers Seriously: Evidence from the Climate Policy." *Journal of Public Administration Research and Theory* 22 (2): 319–46.
Ingold, K. 2011. "Network Structures within Policy Processes: Coalitions, Power, and Brokerage in Swiss Climate Policy." *Policy Studies Journal* 39 (3): 435–59.
Insunza, A., and J. Ortega. 2013. *Bachelet: la historia no oficial*. Santiago de Chile: Catalonia.
Jacobs, L. 1993. The Health of Nations: Public Opinion and the Making of U.S and British Health Policy. Ithaca: Cornell University Press.
Jenkins-Smith, H., D. Norhrstedt, C. Weible, and P. Sabatier. 2014. "The Advocacy Coalition Framework: foundations, evolution, and ongoing research". In: *Theories of the Policy Process*. Sabatier, P. A., and C. M. Weible (Eds). 3rd edition. Boulder, CO: Westview Press.
Jimenez de la Jara, J., and T. Bossert. 1995. "Chile's Health Sector Reform: Lessons from Four Reform Periods." *Health Policy* 32 (1-3): 155–66.
Johnson, J., H. Buttolph, T. Reynolds, and J. D. Mycoff. 2008. *Political Science Research Methods*. 6th ed. Washington, D.C: CQ Press.
Johnson, J. B., and H. T. Reynolds. 2012. *Political Science Research Methods*. Los Angeles: CQ Press.
Joignant, Alfredo & Patricio Navia. 2003. "De la politica de individuos a los hombres del partido. Socializacioon, competencia poliitica y penetracion electoral de la UDI (1989-2001). *Estudios Publicos* 89
Jordan, J. 2009. "Federalism and Health Care Cost Containment in Comparative Perspective". *Publius* 39 (1). [CSF Associates Inc., Oxford University Press]: 164–86.
Kail, B. L., J. Quadagno, and M. Dixon. 2009. "Can States Lead the Way to Universal Coverage? The Effect of Health-Care Reform on the Uninsured." *Social Science Quarterly* 90 (5): 1341–60.
Kaufman, R. and J. Nelson. (Eds.). 2004. *Crucial Needs, Weak Incentives: Social Sector Reform, Democratization, and Globalization in Latin America*. Washington, D.C. : Baltimore: Woodrow Wilson Center Press; Johns Hopkins University Press.
Kay, A. 2005. "A Critique of the Use of Path Dependency in Policy Studies." *Public Administration* 83 (3): 553–71.
Kernell, S. 1997. Going Public: New Strategies of Presidential Leadership. 3rd ed. Washington, D.C: CQ Press.
Kim, P. S. 2012. "Advocacy Coalitions and Policy Change: The Case of South Korea's Saemangeum Project." *Administration & Society* 44 (6 Suppl): 85S – 103S.
King, G., R. Keohane, and S. Verba. 1994. *Designing Social Inquiry: Scientific Inference in Qualitative Research.* Princeton, NJ: Princeton University Press.
Kingdon, J. 1984. *Agendas, Alternatives and Public Policies*. Boston and Toronto: Little, Brown and Company.
Kingdon, J. 2003. *Agendas, Alternatives, and Public Policies*. 2nd ed. Longman Classics in Political Science. New York: Longman.
Korpi, W. 1989. "Power, Politics, and State Autonomy in the Development of Social Citizenship: Social Rights During Sickness in Eighteen OECD Countries Since 1930." *American Sociological Review* 54 (3): 309.
———. 2001. "Contentious Institutions: An Augmented Rational-Actor Analysis of the Origins and Path Dependency of Welfare State Institutions in the Western Countries." *Rationality and Society* 13 (2):235-83.
Kübler, D. 2001. "Understanding Policy Change with the Advocacy Coalition Framework: An Application to Swiss Drug Policy." *Journal of European Public Policy* 8 (4): 623–41.

Kuhlmann, E., R. Blank, I. Bourgeault, and C. Wendt (Eds.). 2015. *The Palgrave International Handbook of Healthcare Policy and Governance*. Palgrave Handbooks. Houndsmills, Basingstoke, Hampshire ; New York, NY: Palgrave Macmillan.

Kwon, S. and M. Reich. 2005. "The Changing Process and Politics of Health Policy in Korea." *Journal of Health Politics, Policy and Law* 30 (6): 1003–26.

Labra, M. E. 1997a. El sistema de salud en Chile. Reformas del pasado, dilemas del presente. *Revista Salud y Cambio*, 6 (23), Pág. 7-22.

———. 1997b. Poder médico y políticas de salud en Chile. Reflexiones para la coyuntura. *Revista Salud y Cambio*, 6 (21), 5-14.

———. 2002. "La Reinvención Neoliberal de La Inequidad En Chile: El Caso de La Salud." *Cadernos de Saúde Pública* 18 (4): 1041–52.

Lagomarsino, G., A. Garabrant, A. Adyas, R. Muga, and N. Otoo. 2012. "Moving towards Universal Health Coverage: Health Insurance Reforms in Nine Developing Countries in Africa and Asia." *The Lancet* 380 (9845): 933–43.

Lagos E., R. 2002. Mensaje Presidencial 21 de mayo del 2002. Available at: http://archivo.fdd.cl:8080/wwwisis/repos/repos1/263993/texto/21Mayo2000.pdf

Landerretche, O. 2014. "Economic Policy and the Ideology of Stability." In *Democratic Chile: The Politics and Policies of a Historic Coalition, 1990-2010*. Sehnbruch, K. and P. Siavelis (Eds.). Boulder, CO: Lynne Rienner Publishers.

Larsen, J. B., K. Vrangbæk, and J. M. Traulsen. 2006. "Advocacy Coalitions and Pharmacy Policy in Denmark—Solid Cores with Fuzzy Edges." *Social Science & Medicine* 63 (1): 212–24.

Leifeld, P. 2013. "Reconceptualizing Major Policy Change in the Advocacy Coalition Framework: A Discourse Network Analysis of German Pension Politics." Policy Studies Journal 41 (1): 169–98.

Levitsky, S., and K. M. Roberts. *The Resurgence of the Latin American Left.* Baltimore: Johns Hopkins University Press, 2011.

Lijphart, A. 1999. Patterns of Democracy: Government Forms and Performance in Thirty-Six Countries. New Haven: Yale University Press.

Lipset, S. M. 1996. *American Exceptionalism*. New York: W.W. Norton.

Londoño, J. L., and J. Frenk. 1997. "Structured Pluralism: Towards an Innovative Model for Health System Reform in Latin America." *Health Policy* 41 (1): 1–36.

Lloyd Sherlock, P. 2013. "Inequality and social policy in Latin America: A new analytical framework". In: *The Routledge Handbook of the Welfare State.* Greve, Bent. London; New York: Routledge.

Lukes, S. 2005. *Power: A Radical View.* 2nd edition. Basingstoke: Palgrave Macmillan.

Luna, J. P. 2014. Segmented Representation: Political Party Strategies in Unequal Democracies. Oxford: Oxford University Press.

MacDonald, K. 2001. "Using documents". In: *Researching social life.* Gilbert, N. (Ed.). London: Sage.

Mahoney, J. 2000. "Path Dependence in Historical Sociology." *Theory and Society* 29 (4): 507–48.

Mahoney, J., and K. Thelen, (Eds.). 2010. *Explaining Institutional Change: Ambiguity, Agency, and Power*. Cambridge ; New York: Cambridge University Press.

Maioni, A. 1998. Parting at the Crossroads: The Emergence of Health Insurance in the United States and Canada. Princeton: Princeton University Press.

Mardones-Restat, F., and A. de Azevedo. 2006. "The Essential Health Reform in Chile: A Reflection on the 1952 Process." *Salud Pública de México* 48 (6): 504–11.

Mares, I., and M. E. Carnes. 2009. "Social Policy in Developing Countries." *Annual Review of Political Science* 12 (1): 93–113.

Marmor, T., and C. Wendt. 2012. “Conceptual Frameworks for Comparing Healthcare Politics and Policy.” *Health Policy* 107 (1): 11–20.

Matti, S., and A. Sandström. 2011. “The Rationale Determining Advocacy Coalitions: Examining Coordination Networks and Corresponding Beliefs.” *Policy Studies Journal* 39 (3): 385–410.

McGuire, J. W. 2010. *Wealth, Health, and Democracy in East Asia and Latin America*. Cambridge: Cambridge University Press.

Méndez, C. A. 2014. “Global Health Politics: Neither Solidarity nor Policy; Comment on ‘Globalization and the Diffusion of Ideas: Why We Should Acknowledge the Roots of Mainstream Ideas in Global Health.” *International Journal of Health Policy and Management* 3 (2): 103–5.

Menahem, G. and Gilad, S. 2016. “Policy Stalemate and Policy Change in Israel's Water Sector 1970–2010: Advocacy Coalitions and Policy Narratives”. *Review of Policy Research,* 33: 316–337.

Mesa-Lago, C. 2005. Las reformas de salud en América Latina y el Caribe: su impacto en los principios de seguridad social. Santiago de Chile: CEPAL.

Mesa-Lago, C. 2008. “Social Protection in Chile: Reforms to Improve Equity.” *International Labour Review* 147 (4): 377–402.

Ministry of Health Report. 2004. Reforma a la salud 2004. Ministerio de Salud.

Monckeberg, M. O. 2001. *El Saqueo de Los Grupos Económicos Al Estado Chileno*. Crónica Actual. Santiago de Chile: Ediciones B.

Montefrio, M. 2014. “State versus Indigenous Peoples’ Rights: Comparative Analysis of Stable System Parameters, Policy Constraints and the Process of Delegitimation.” *Journal of Comparative Policy Analysis: Research and Practice* 16 (4): 335–55.

Montoya-Aguilar, C. 2013. La salud dividida: Chile 1990-2012 ; ideología, debates y decisiones acerca de la salud ; lo que dicen los documentos del período de los gobiernos de la Concertación. Colección Ensayo. Santiago de Chile: Ceibo Ediciones.

Montpetit, E. 2011. “Scientific Credibility, Disagreement, and Error Costs in 17 Biotechnology Policy Subsystems.” *Policy Studies Journal* 39 (3): 513–33.

Montt, J. 2005. *Reforma de la Salud en Chile: Desafíos de la Implementación.* En*:* Sánchez, H. and J. Labbé (Eds)*.* Santiago: Instituto de Políticas Públicas y Gestión en Salud, Salud Y Futuro, Universidad Andrés Bello.

Moran, M. 1995. “Three Faces of the Health Care State.” *Journal of Health Politics, Policy and Law* 20 (3): 767–81.

Muennig, P., and C. Su. 2013. *Introducing Global Health: Practice, Policy, and Solutions*. San Francisco: Jossey-Bass, a Wiley brand.

Murray, S, and M. A. Elston. 2005. “The Promotion of Private Health Insurance and Its Implications for the Social Organisation of Healthcare: A Case Study of Private Sector Obstetric Practice in Chile.” *Sociology of Health & Illness* 27 (6).

Nancuante, U., and A. Romero. 2008. *La reforma de la salud*. 1. ed. Santiago: Instituto de Políticas Públicas y Gestión, Salud y Futuro.

Navarro, V., J. Schmitt, and J. Astudillo. 2004. “Is Globalization Undermining the Welfare State? The Evolution of the Welfare State in Developed Capitalist Countries during the 1990s.” *International Journal of Health Services* 34 (2): 185–227

Navarro, V. 2008. “Politics and Health: A Neglected Area of Research.” *The European Journal of Public Health* 18 (4): 354–55.

Navia, P., and R. Osorio. 2015. “*El Mercurio* Lies, and *La Tercera* Lies More. Political Bias in Newspaper Headlines in Chile, 1994-2010: Political Bias in Chilean Newspaper Headlines, 1994-2010.” *Bulletin of Latin American Research* 34 (4): 467–85.

Nelson, J. 2004. “The politics of Health Sector Reform: Cross-National Comparisons”. In: *Crucial Needs, Weak Incentives: Social Sector Reform, Democratization, and Globalization in Latin America*. Kaufman, R. and J. Nelson. (Eds.). Washington, D.C. : Baltimore: Woodrow Wilson Center Press; Johns Hopkins University Press.

Nelson, J. 2007. “Elections, Democracy, and Social Services.” *Studies in Comparative International Development* 41 (4): 79–97.

Nohrstedt, D. 2011. “Shifting Resources and Venues Producing Policy Change in Contested Subsystems: A Case Study of Swedish Signals Intelligence Policy.” *Policy Studies Journal* 39 (3): 461–84.

Odendahl, T and A. Shaw 2002. “Interviewing Elites”. In: *Handbook of Interview Research: Context and Metho.* Gubrium, J. F., and J. Holstein*.* Thousand Oaks, CA: Sage

Olavarría, M. (Ed). 2011. *¿Cómo Se Formulan Las Políticas Públicas En Chile?*. Estudios. Santiago de Chile: Editorial Universitaria.

Oliver, T. R. 2006. “The politics of public health policy.” *Annual Review of Public Health* 27 (1): 195–233.

Oppenheim, L. 2006. “Chilean Economic Policy under the Concertacioon: The Triumph of the Market?”. In: *After Pinochet: The Chilean Road to Democracy and the Market*. Borzutzky, S. and L. Oppenheim (Eds). Gainesville, FL: University Press of Florida.

Ossandon, J. 2008. “The Enactment of Private health insurance in Chile”. PhD. Thesis, Goldsmiths, University of London.

Passarelli. G. 2015. The Presidentialization of Political Parties: Organizations, Institutions and Leaders. Basingstoke: Palgrave Macmillan.

Perera-Mubarak, K. 2014. “Power play: ethical dilemmas of dealing with local officials and politicians”. In: *Fieldwork in the Global South*. Lunn, J. London and New York: Routledge.

Peters, G., J. Pierre and D. S. King. 2005. “The Politics of Path Dependency; Political Conflict in Historical Institutionalism”. *Journal of Politics,* 67(4), pp 1275-1300

Pierce, J. J. 2011. “Coalition Stability and Belief Change: Advocacy Coalitions in U.S. Foreign Policy and the Creation of Israel, 1922–44.” *Policy Studies Journal* 39 (3): 411–34.

Pierson, P. 1994. Dismantling the Welfare State? Reagan, Thatcher, and the Politics of Retrenchment. Cambridge: Cambridge University Press.

Pierson, P. 1996. “The Path to European Integration: A Historical Institutionalist Analysis.” *Comparative Political Studies* 29 (2): 123–63.

Pierson, P. 2000. “Increasing Returns, Path Dependence, and the Study of Politics”. *American Political Science Review*, vol. 94(2), pp. 251-67.

Pierson, P. (Ed). 2001. *The New Politics of the Welfare State*. Oxford, New York: Oxford University Press.

Pribble, J. 2008. “Protecting the poor: welfare politics in Latin America’s free market era”. PhD dissertation, University of North Carolina at Chapel Hill.

Pribble, J., Huber E. and J. Stephens. 2009. “Politics, Policies, and Poverty in Latin America.” *Comparative Politics*. Vol. 41 (4): 387-407.

———.2013. *Welfare and Party Politics in Latin America*. 1. ed. New York: Cambridge Univ. Press.

Pushkar. 2006. “Explaining Paralysis in Chile’s Health Sector, 1990-2000.” *International Journal of Health Services* 36 (3): 605–22.

Quadagno, J. 2010. “Institutions, Interest Groups, and Ideology: An Agenda for the Sociology of Health Care Reform.” *Journal of Health and Social Behavior* 51 (2): 125–36.

Ramírez, P. 2004 “A Sweeping Health Reform: the Quest for Unification, Coverage and Efficiency in Colombia”. In: *Crucial Needs, Weak Incentives: Social Sector Reform, Democratization, and Globalization in Latin America*. Kaufman, R. and J. Nelson. (Eds.). Baltimore: Woodrow Wilson Center Press; Johns Hopkins University Press.

Rechel, B. 2015. “Health Policy Reform in Former Soviet Union”. In: *The Palgrave International Handbook of Healthcare Policy and Governance*. Kuhlmann, E., R. Blank, I. Bourgeault, and C. Wendt (Eds.). Palgrave Handbooks. Houndsmills, Basingstoke, Hampshire ; New York, NY: Palgrave Macmillan.

Reichard, S. 1996. “Ideology Drives Health Care Reforms in Chile”. *Journal of Public Health Policy* Vol. 17, No. 1.

Rhodes, R. A. W., S. A. Binder, and B. A. Rockman, eds. 2008. *The Oxford Handbook of Political Institutions*. Oxford: Oxford University Press

Rice, T., L. Y. Unruh, P. Rosenau, A., J. Barnes, R. B. Saltman, and E. Van Ginneken. 2014. “Challenges Facing the United States of America in Implementing Universal Coverage.” *Bulletin of the World Health Organization* 92 (12): 894–902.

Richardson, I. (Ed.). 1982. *Policy Styles in Western Europe*. London: Allen and Unwin.

Riesco, M. ed. 2007. *Latin America: A New Developmental Welfare State Model in the Making?*. Social Policy in a Development Context. Basingstoke, New York: Palgrave Macmillan/UNRISD.

Roberts, A. 2009. “The Politics of Healthcare Reform in Postcommunist Europe: The Importance of Access.” *Journal of Public Policy* 29 (03): 305.

Roberts, K. 1998. Deepening Democracy? The Modern Left and Social Movements in Chile and Peru. Stanford: Stanford University Press.

Rubin, H. J., and I. Rubin. 2011. *Qualitative Interviewing: The Art of Hearing Data*. 3rd ed. Thousand Oaks, Calif: SAGE.

Sabatier, P. A. 1993. Policy change over a decade or more. In: *Policy Change and Learning: An Advocacy Coalition Approach*. Theoretical Lenses on Public Policy. Sabatier, P. A., and H. Jenkins-Smith (Eds.). Boulder, CO: Westview Press.

Sabatier, P. ed. 2007. *Theories of the Policy Process*. 2nd ed. Boulder, CO: Westview Press.

Sabatier, P. A., and H. Jenkins-Smith. (Eds). 1993. *Policy Change and Learning: An Advocacy Coalition Approach*. Theoretical Lenses on Public Policy. Boulder, CO: Westview Press.

Sabatier, P. and H. Jenkins-Smith. 1999. “The Advocacy Coalition Framework: An Assesment.” In: *Theories of the Policy Process*. Sabatier, P. (Ed). Boulder, CO: Westview Press.

Sabatier, P. and C. Weible. 2007. “The Advocacy Coalition Framework: Innovations and Clarifications.” In: *Theories of the Policy Process*. Sabatier, P (Ed). 2nd ed. Boulder, Colorado: Westview Press.

Sabatier, P., and C. M. Weible, Eds. 2014. *Theories of the Policy Process*. Third edition. Boulder, CO: Westview Press.

Savedoff, W. D., D. De Ferranti, A. L. Smith, and V. Fan. 2012. “Political and Economic Aspects of the Transition to Universal Health Coverage.” *The Lancet* 380 (9845): 924–32.

Scartascini, C. 2011. “¿Quién es quién en el juego político? Describiendo a los actores que intervienen, y sus incentivos y funciones”. En: *El juego político en América Latina: ¿Cómo se deciden las políticas públicas?.* Scartascini, C., P. Spiller, E. Stein y M. Tommasi, editores. BID, Colombia.

Schlager, E. 1995. “Policy Making and Collective Action: Defining Coalitions within the Advocacy Coalition Framework.” *Policy Sciences* 28 (3): 243–70.

Seawright, J., and J. Gerring. 2008. “Case Selection Techniques in Case Study Research: A Menu of Qualitative and Quantitative Options.” *Political Research Quarterly* 61 (2): 294–308

Sehnbruch, K., and P. Siavelis, (Eds.). 2014. *Democratic Chile: The Politics and Policies of a Historic Coalition, 1990-2010*. Boulder, CO: Lynne Rienner Publishers.

Shanahan, E. A., M. D. Jones, and M. K. McBeth. 2011. “Policy Narratives and Policy Processes.” *Policy Studies Journal* 39 (3): 535–61.

Siavelis, P. 2000. The President and Congress in Postauthoritarian Chile: Institutional Constraints and Democratic Consolidation. University Park: Pennsylvania State University Press.

Siavelis, P. 2016. “Bachelet Is Back: Reform Prospects and the Future of Democracy in Chile”. In: *Gender, institutions, and change in Bachelet’s Chile.* Waylen, G. (Ed.). New York City: Palgrave Macmillan.

Silverman, D. 2010. Doing Qualitative Research: a Practical Handbook. London: SAGE.

Skocpol, T., and P. Pierson. 2002. “Historical Institutionalism in Contemporary Political Science.” In *Political Science: State of the Discipline*. Katznelson, I., and H. Milner. 693–721. New York: W.W. Norton.

Skocpol, T., and L. R. Jacobs. 2012. “Accomplished and Embattled: Understanding Obama’s Presidency.” *Political Science Quarterly* 127 (1): 1–24.

Sotirov, M. and M. Memmler. 2012. “The Advocacy Coalition Framework in Natural Resource Policy Studies — Recent Experiences and Further Prospects.” *Forest Policy and Economics* 16 (March): 51–64.

Stallings, B. 1993. "*The Political Economy of Economic Adjustment: Chile 1973-90*," in Robert H. Bates and Anne O. Krueger, eds. Political and Economic Interactions in Economic Policy Reform. Oxford: Basil Blackwell.

Starke, P. 2006. “The Politics of Welfare State Retrenchment: A Literature Review.” *Social Policy & Administration* 40 (1): 104–20.

Starr, P. 1982. *The Social Transformation of American Medicine*. New York: Basic Books.

Stein, E., M. Tommasi, P. T. Spiller (Eds). 2008. *Policymaking in Latin America: How Politics Shapes Policies*. Washington, DC: Inter-American Development Bank and David Rockefeller Center for Latin American Studies.

Steinmo, S., K. Thelen, and F. Longstreth. (eds.). 1990. *Structuring Politics: Historical Institutionalism in Comparative Analysis*. Cambridge: Cambridge University Press.

Steinmo, S., and J. Watts. 1995. “It’s the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America.” *Journal of Health Politics, Policy and Law* 20 (2): 329–72.

Stream, C. 1999. “Health Reform in the States: A Model of State Small Group Health Insurance Market Reforms.” *Political Research Quarterly* 52 (3): 499.

Streeck, W., and K. Thelen (Eds). 2005. *Beyond Continuity: Institutional Change in Advanced Political Economies*. Oxford ; New York: Oxford University Press.

Studlar, D. T., and P. Cairney. 2014. “Conceptualizing Punctuated and Non-Punctuated Policy Change: Tobacco Control in Comparative Perspective.” *International Review of Administrative Sciences* 80 (3): 513–31.

Swanborn, P. 2010. Case Study Research What, Why and How?. London: SAGE

Swank, D. 2001. “Political Institutions and Welfare State Restructuring: The Impact of Institutions on Social Policy Change in Developed Democracies.” in: *The New Politics of the Welfare State*. Pierson, P. (Ed.). Oxford: Oxford University Press.

Swank, D. 2002. Global Capital, Political Institutions, and Policy Change in Developed Welfare States. New York: Cambridge University Press.

Tanzi, V. 2002. “Globalization and the Future of Social Protection.” *Scottish Journal of Political Economy* 49 (1): 116–27

Taylor, M. 2003. “The Reformulation of Social Policy in Chile, 1973-2001: Questioning a Neoliberal Model.” *Global Social Policy* 3 (1): 21–44.

———. 2006. From Pinochet to the “Third Way”: Neoliberalism and Social Transformation in Chile. London ; Ann Arbor, MI: Pluto Press.

Teichman J. 2012. Social Forces and States: Poverty and Distributional Outcomes in South Korea, Chile, and Mexico. Redwood City, CA: Stanford University Press.

Thelen, K. 1999. “Historical institutionalism in comparative politics.” *Annual Review of Political Science* 2 (1): 369–404.

Titelman, D. 2000. *Reformas al Sistema de Salud en Chile: Desafíos pendientes*. CEPAL, Unidad de Comercio Internacional y Financiamiento del Desarrollo. Naciones Unidas.

Toth, F. 2010. "Is There a Southern European Healthcare Model?" *West European Politics* 33 (2): 325–43.

True, J., B. Jones, and F. Baumgartner. 2007. "Punctuated-Equilibrium Theory Explaining Stability and Change in Public Policymaking". In: Sabatier, P. (Ed.), *Theories of the policy process* (2nd ed.) Boulder, CO: Westview Press.

Trumper, R., and L. Phillips. 1997. "Give Me Discipline and Give Me Death: Neoliberalism and Health in Chile." *International Journal of Health Services* 27 (1): 41–55.

Tsebelis, G. 1995. "Decision Making in Political Systems: Veto Players in Presidentialism, Parliamentarism, Multicameralism and Multipartyism." *British Journal of Political Science* 25 (03): 289.

Thumala, M. A. 2007. Riqueza y piedad. El catolicismo de la elite economica chilena. Santiago, Debate-Random House Mondadori.

Tuohy, C. H. 1999. Accidental logics. The dynamics of change in the health care system in the United States, Britain and Canada. New York: Oxford University Press;

Ulin, P., E. Robinson, and E. Tolley. 2005. Qualitative methods in public health a field guide for applied research. San Francisco, CA

Undurraga, T. Rearticulacion de grupos economicos y renovacion ideological del empresariado en Chile 1980-2010. Serie Working papers, ICSO-UDP.

Unidad de Apoyo al Proceso Legislativo. 2003. *Reforma de salud: Fondo de Compensación Solidario*. Valparaíso: Biblioteca del Congreso Nacional de Chile.

Unger, J. P., P. De Paepe, G. Solimano, and O. Arteaga. 2008. "Chile's Neoliberal Health Reform: An Assessment and a Critique." *PLoS Medicine* 5 (4): e79.

Valenzuela, S. 1997. *La Constitución de 1980 y el Inicio de la Redemocratización en Chile.* Working Paper #242. Kellogg Institute, University of Notre Dame.

Van Evera, S. 1997. Guide to Methodology for Students of Political Science. Ithaca: Cornell University Press

Van Nes, F., T. Abma, H. Jonsson, and D. Deeg. 2010. "Language Differences in Qualitative Research: Is Meaning Lost in Translation?" *European Journal of Ageing* 7 (4): 313–16

Varas, A., I. Castillo, P. Díaz-Romero, and I. Jaksic. 2012. *La Democracia Frente Al Poder: Chile, 1990-2010*. 1. ed. Santiago de Chile: Catalonia.

Visser, J., and A. Hemerijck. 1997. A Dutch Miracle: Job Growth, Welfare Reform and Corporatism in the Netherlands. Amsterdam: Amsterdam University Press.

Walt, G, and L. Gilson. "Reforming the Health Sector: The Central Role of Policy Analysis." *Health Policy and Planning* 9: 353–370.

Walt, G., J. Shiffman, H. Schneider, S. F. Murray, R. Brugha, and L. Gilson. 2008. "'Doing' Health Policy Analysis: Methodological and Conceptual Reflections and Challenges." *Health Policy and Planning* 23 (5): 308–17.

Walt, G. 1994. Health Policy: An Introduction to Process and Power. London: Zed Press.

Ward, P. M. 1993. "Social Welfare Policy and Political Opening in Mexico." *Journal of Latin American Studies* 25 (03): 613.

Waylen, G. 2014. "Informal Institutions, Institutional Change, and Gender Equality." *Political Research Quarterly* 67 (1): 212–23.

Weible, C., P. Sabatier, and J. Flowers. 2008. "Advocacy Coalition Framework." *Encyclopedia of Public Administration and Public Policy*. Taylor & Francis.

Weible, C. M., P. Sabatier, and K. McQueen. 2009. "Themes and Variations: Taking Stock of the Advocacy Coalition Framework." *Policy Studies Journal* 37 (1): 121–40.

Weible, C. M., P. A. Sabatier, H. C. Jenkins-Smith, D. Nohrstedt, A. D. Henry, and P. de Leon. 2011. "A

Quarter Century of the Advocacy Coalition Framework: An Introduction to the Special Issue." *Policy Studies Journal* 39 (3): 349–60.

Wendt, C., L. Frisina, and H. Rothgang. 2009. "Healthcare System Types: A Conceptual Framework for Comparison." *Social Policy & Administration* 43 (1): 70–90.

Weyland, K. 1996. *Democracy without Equity.* Pittsburgh: University of Pittsburgh Press.

———.2005. "Theories of Policy Diffusion Lessons from Latin American Pension Reform." *World Politics* 57 (02): 262–95.

———.2006. Bounded Rationality and Policy Diffusion: Social Sector Reform in Latin America. Princeton: Princeton University Press.

Wilensky, H. 1975. The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures. Berkeley and Los Angeles: University of California Press.

———.2009. U.S. Health Care and Real Health in Comparative Perspective: Lessons from Abroad. *The Forum* 7: 1-18.

Wong, J. 2006. *Healthy Democracies: Welfare Politics in Taiwan and South Korea*. Ithaca, N.Y.; Bristol: Cornell University Press.

Wong, N. W. M. 2015. "Advocacy Coalitions and Policy Change in China: A Case Study of Anti-Incinerator Protest in Guangzhou." *VOLUNTAS: International Journal of Voluntary and Nonprofit Organizations*, May.

World Bank. 1993. World Development Report 1993: Investing in Health, Volume1. The World Bank. Available at: http://elibrary.worldbank.org/doi/book/10.1596/0-1952-0890-0.

Yin, R. K. 2002. *Case study research: Design and methods.* SAGE Publications Ltd.

Zafonte, M., and P. Sabatier. 2004. "Short-Term Versus Long-Term Coalitions in the Policy Process: Automotive Pollution Control, 1963-1989." *Policy Studies Journal* 32(1): 75-107.

Zahariadis, N. 2007. "The Multiple Streams Framework: Structure, Limitations, Prospects in Public Policymaking". In Sabatier, P. (Ed.), Theories of the policy process (2nd ed.) Boulder, CO: Westview Press.

THINK TANKS PUBLICATIONS

Aedo, C. 1994. "Sector salud en Chile: un gran desafío", en Larraín, F. *Chile hacia el 2000*. Santiago: Centro de Estudios Públicos.

----------. 2001. "Las reformas en la salud en Chile". En: Larraín, F. y R. Vergara. *La transformación económica de Chile*. Santiago de Chile: Centro de Estudios Públicos,

----------. 1996. "Los problemas de salud del adulto mayor y las enfermedades catastróficas". *Estudios Públicos*, N° 63.

Aedo, C. y C. Sapelli. 1999. "Una propuesta para la reforma del sistema de seguros de salud en Chile". *Estudios Públicos*, N° 75.

----------. 1999. "El sistema de salud en Chile: readecuar el mandato y reformar el sistema de seguros". *Estudios Públicos,* N° 75.

Beyer, H. y J. I. Bordalí. 1989. "Fortalecimiento del sector privado: una alternativa para la salud". *Estudios Públicos*, N° 34.

Beyer, H. 2001. "Propuestas necesarias para el sector salud", en Beyer, H. y R. Vergara. (Eds.) *Qué hacer ahora: propuestas para el desarrollo*. Santiago de Chile: Centro de Estudios Públicos.

Caviedes, R. 1994. “Subsidio a la demanda: una propuesta para mejorar la salud”, en Larraín, F. *Chile hacia el 2000.* Santiago: Centro de Estudios Públicos.

Centro de Estudios Publicos. 2002. *Encuesta de Opinion Publica*. Julio y Diciembre. Disponible en: http://www.cepchile.cl/enc_main.html

Erazo, A. 2004. “La Reforma de Salud: una obligación Social”. En *Revista Foro*. Fundación Chile 21.

Instituto Libertad y Desarrollo. 2003. “¿Daño previsional o subcotización del Estado?”, Temas Públicos, N° 616.

———.1996. “AFP: el dilema de los costos de comercialización”, Temas Públicos, N° 300.

———. 2004.“Sistema de pensiones: percepciones y realidades”, Temas Públicos, N° 672.

———.2001. “Salud: libertad de elección y eficiencia”. En Larroulet, C.: *Chile 2010: el desafío del desarrollo*. Santiago de Chile: Libertad y Desarrollo, 2001.

Jiménez de la Jara, J. 2003. “Salud: la reforma larga que baja y se pierde”. Asuntos Públicos, N° 270.

———.2002. “Cambios en salud”. Asuntos Públicos, N° 57.

Lenz, R. 2007. “Proceso Politico de la reforma AUGE de salud en Chile: algunas lecciones para America Latina. Una mirada desde la economia politica”. Serie Estudios Socio/ Económicos 38. Santiago de Chile: CIEPLAN.

Miranda, E. 1994. “Sistemas de salud en el mundo. Parte I: un marco conceptual para el análisis”, en Miranda, E. (ed.). *La salud en Chile: evolución y perspectivas.* Santiago de Chile: Centro de Estudios Públicos.

Oyarzo, C. 1994. “La mezcla público-privada: una reforma pendiente en el sector salud”, Estudios Públicos, N° 55.

Oyarzo, C. and M. Vergara. 2005. “Reforma de la Salud en Chile: lo logrado y lo pendiente”. *En Foco*, Expansiva. Vol. 42.

Sánchez, H. and J. Labbé (Eds). 2005. *Reforma de la Salud en Chile: Desafíos de la Implementación.* Santiago de Chile: Instituto de Políticas Públicas y Gestión en Salud, Salud Y Futuro, Universidad Andrés Bello.

Vergara, M. 2007. “Reforma del sector de la salud en Chile: Avances y problemas en la implementación”. *En Foco*, Expansiva. Vol. 112.

TRANSCRIPTIONS OF CONGRESSIONAL HEARINGS

Chilean Congress. 2004. History of Law No.19.966. Establece un régimen de garantías de salud. Valparaiso: Congreso, Chile.

Chilean Congress. 2003. History of Law No.19.859. Establece diversas normas de solvencia y protección de personas incorporadas a instituciones de salud previsional, administradora de fondos de pensiones y compañías de seguros. Valparaiso: Congreso, Chile.

Chilean Congress. 2003. History of Law No.19.888. Financiamiento necesario para asegurar objetivos sociales prioritarios del Gobierno. Valparaiso: Congreso, Chile.

Chilean Congress. 2004. History of Law No.19.937. Modifica el D.L. 2763 de 1979, con la finalidad de establecer una nueva concepción de la autoridad sanitaria, distintas modalidades de gestión y fortalecer la participación ciudadana. Valparaiso: Congreso, Chile.

Chilean Congress. 2005. History of Law No.20.015. Modifica la Ley No 18.933, sobre Instituciones de Salud Previsional. Valparaiso: Congreso, Chile.

NEWSPAPERS (CITED)

El Mercurio.2001. “Comienza Discusión De Reforma de Salud”, January 6.

————. 2002. “Rechazo a reforma de la salud”, May 10.

————. 2002. “Afinidad entre empresarios y el PDC en tema de salud”, May 10.

————. 2002. “El Gobierno quita urgencia a leyes AUGE”, July 12.

————. 2002. “*Poco auge en las reformas*”, December 29.

————. 2002. “COLEGIO MEDICO DE CHILE (A.G.)”, December 29.

————. 2004. “Plan Auge: Salud transo fondo”, May 13.

La Nación. 2001. “La comunidad podrá participar en proceso de reforma de la salud”, January 6

————. 2001. “Informe busca entrabar reforma a la salud”, May 6.

————. 2001. “El reto de la solidaridad en salud”, May 15.

————. 2002. “En defensa de la salud pública”, July 13.

————. 2002. “Zaldívar encabeza una reunión clave para posicionar a la DC”, July 13.

————. 2002. “El debate por las urgencias”, July 13.

La Segunda. 2002. “Foxley enciende alerta por últimos vuelcos en Salud”, May 14.

La Tercera. 2002. “Salud: pierde terreno recorte a isapres para Auge”, May 3.

————. 2002. “La reforma a la Salud, según Foxley y Boeninger”, May 5.

————. 2002. “Hacienda y DC forman equipo tecnico para cambiar financiamiento del AUGE”, June 6.

————. 2002. “Médicos critican seis puntos de la reforma”, June 13.

————. 2002. “Vínculos con las isapres complican al gremialismo”, July 13.

————. 2003. “Exigen mejorar atención de pacientes”, March 7.

————. 2003. “Gobierno abierto a desechar alza de impuestos para alcohols y diesel”, June 10.

————. 2003. “Dudas sobre el Auge”, June 10.

————. 2003. “Gobierno defiende el Auge y asegura que costo de $ 153 mil millones se mantiene”, June 10.

Revista Qué Pasa. 2002. “La fórmula para salvar a Eyzaguirre”, May 31.

————————.2002. “La agenda pro lobby”, May 31.

APPENDICES

Appendix A. ETHICAL RESEARCH COMMITTEE APPROVAL

KING'S College LONDON

26th November 2012

Oriana Piffre
Department of Management

Dear Oriana,

REP(EM)/12/13-3 'Understanding constructs to health policy change in post-dictatorship Chile.'

I am pleased to inform you that the above application has been reviewed by the E&M Research Ethics Panel that FULL APPROVAL is now granted.

Please ensure that you follow all relevant guidance as laid out in the King's College London Guidelines on Good Practice in Academic Research (http://www.kcl.ac.uk/college/policyzone/index.php?id=247).

For your information ethical approval is granted until 22/11/14. If you need approval beyond this point you will need to apply for an extension to approval at least two weeks prior to this explaining why the extension is needed, (please note however that a full re-application will not be necessary unless the protocol has changed). You should also note that if your approval is for one year, you will not be sent a reminder when it is due to lapse.

Ethical approval is required to cover the duration of the research study, up to the conclusion of the research. The conclusion of the research is defined as the final date or event detailed in the study description section of your approved application form (usually the end of data collection when all work with human participants will have been completed), not the completion of data analysis or publication of the results. For projects that only involve the further analysis of pre-existing data, approval must cover any period during which the researcher will be accessing or evaluating individual sensitive and/or un-anonymised records. Note that after the point at which ethical approval for your study is no longer required due to the study being complete (as per the above definitions), you will still need to ensure all research data/records management and storage procedures agreed to as part of your application are adhered to and carried out accordingly.

If you do not start the project within three months of this letter please contact the Research Ethics Office.

Should you wish to make a modification to the project or request an extension to approval you will need approval for this and should follow the guidance relating to modifying approved applications:
http://www.kcl.ac.uk/innovation/research/support/ethics/applications/modifications.aspx
The circumstances where modification requests are required include the addition/removal of participant groups, additions/removal/changes to research methods, asking for additional data from participants, extensions to the ethical approval period. Any proposed modifications should only be carried out once full approval for the modification request has been granted.

Any unforeseen ethical problems arising during the course of the project should be reported to the approving committee/panel. In the event of an untoward event or an adverse reaction a full report must be made to the Chair of the approving committee/review panel within one week of the incident.

Please would you also note that we may, for the purposes of audit, contact you from time to time to ascertain the status of your research.

If you have any query about any aspect of this ethical approval, please contact your panel/committee administrator in the first instance (http://www.kcl.ac.uk/innovation/research/support/ethics/contact.aspx). We wish you every success with this work.

Yours sincerely

_____

Daniel Butcher
Research Ethics Officer

Appendix B. INFORMATION SHEET AND CONSENT FORM

HOJA INFORMATIVA PARA PARTICIPANTES

REC Reference Number REP(EM)/12/13-3

UNA COPIA DE ESTA HOJA LE SERA ENTREGADA

KING'S College LONDON

"Understanding constraints to health policy change in Chile (2000-2006)"

Quisiéramos invitarle a participar en este proyecto de investigación de postgrado. Su participación es absolutamente voluntaria, por lo que si usted decide no hacerlo, no tendrá ningún tipo de repercusión para usted. Antes de decidir, si quiere participar o no, es importante que usted comprenda las razones de este estudio y cual será su rol en el.

Por favor, lea atentamente la siguiente información. Si tiene alguna pregunta o desea conocer mas detalles del proyecto, no dude en contactarnos.

Esta investigación de tesis doctoral busca examinar los factores y actores que intervinieron en la implementación de la reforma a la salud en Chile durante la administración del Presidente Lagos (2000-2006). Este estudio incluye el análisis de documentos y fuentes secundarias, así como entrevistas con actores relevantes durante el proceso en que la reforma fue diseñada, discutida y aprobada. Este grupo de actores incluye autoridades de gobierno, parlamentarios, políticos, representantes del sector privado, y lideres de gremios durante el periodo señalado.

Como participante en este proyecto, usted será consultado acerca de su opinión e interpretación sobre algunos eventos u otros actores relacionados con la reforma a la salud. Por ejemplo, usted podrá ser consultado acerca de las personas que tuvieron mas influencia en la reforma, o que tipo de vías de comunicación se usaban con mayor frecuencia durante ese período, entre otras.

La entrevista será realizadas de acuerdo a su disponibilidad en términos de tiempo y lugar Sujeto a su aprobación, la entrevista será grabada y luego transcrita personalmente por el investigador Apuntes y grabaciones serán eliminadas luego de su transcripción.

Si usted decide participar, le entregaremos esta hoja informativa y le pediremos que firme un formulario de consentimiento, en el cual usted acepta participar y ser identificado en su contribución a este estudio. Dadas las características de esta investigación, la información y los datos entregados será utilizados solo en el caso que usted acepte participar
Es importante señalar que la confidencialidad de este estudio y el uso de los datos esta regulado por el Acta de Protección de Datos de 1998 (Legislación Británica).

Derecho a retirarse:

Como participante en este estudio, usted puede retirarse sin necesidad de justificación y puede hacerlo enviando un correo electrónico al investigador (oriana.piffre@kcl.ac.uk) solicitando su remoción del estudio. En dicho caso, los datos de la entrevista serán destruidos y excluidos de la investigación. La fecha límite para solicitarlo es el día 30 de Septiembre de 2014.

Si usted tiene alguna pregunta o necesita mayor información acerca de este estudio, por favor contacte al investigador usando los siguientes datos:

Oriana Piffre
Department of Management
School of Social Science and Public Policy
King's College London
Franklin-Wilkins Building
150 Stamford Street
London SE1 9NH
Tel UK: +44 7428004294
Tel Chile: + 56 9694699560
email: oriana.piffre@kcl.ac.uk

Si este estudio lo ha afectado en alguna manera, usted puede contactar a King's College London usando los siguientes datos para mayor información y consejos:

Dr Juan Baeza
Lecturer
Department of Management
School of Social Science and Public Policy
King's College London
Franklin-Wilkins Building
150 Stamford Street
London SE1 9NH
Tel UK: +44 020 7848 4634
email: juan.baeza@kcl.ac.uk

FORMULARIO DE CONSENTIMIENTO PARA PARTICIPANTES EN INVESTIGACIONES

Por favor, complete este formulario después de haber leído la hoja de información y/o haber escuchado la explicación acerca de la investigación.

Título del estudio: "Understanding constraints to health policy change in Chile (2000-2006)"

King's College Research Ethics Committee Ref: *REP(EM)/12/13-3*

Gracias por participar en esta investigación. La persona a cargo del estudio debe explicarle el proyecto antes de que usted acepte participar. Si usted tiene preguntas acerca de la hoja de información o de la explicación que se le ha dado, por favor, pregúntele al investigador antes de decidir si participa o no. Se le entregara copia de este formulario.

Marque con una X

- Entiendo que puedo renunciar a participar en este proyecto sin justificación alguna. Para ello, debo notificar al investigador responsable de mi decisión antes de el 30 de Septiembre de 2014, vía correo electrónico. ☐
- Estoy de acuerdo con el manejo de la información con los propósitos a mi explicados por el investigador. Acepto que esta información sea analizada de acuerdo al Acta de Protección de Datos 1998. ☐
- **IDENTIFICACIÓN**

  Estoy de acuerdo con ser identificado y asociado con mi contribución a este estudio, y en los productos académicos (tesis, artículos, libros y presentaciones en conferencias académicas), que puedan ser publicados por el investigador ☐

- Acepto que mi entrevista sea grabada.

Si	No

Declaración del participante:

Yo _____

Acepto que el proyecto de investigación señalado arriba me ha sido explicado satisfactoriamente y estoy de acuerdo en participar en el. He leído la hoja de información y este formulario de consentimiento, y entiendo las implicancias de este estudio.

Firma Fecha

Appendix C. MAIL CONTACT

From: "Piffre, Oriana" <oriana.piffre@kcl.ac.uk>
Subject: Contacto Entrevista- Tesis Doctoral King's College London
Date: January 2014 20:13:26 GMT
To: XX

Estimad(a) XX

Mi nombre es Oriana Piffre, estudiante de doctorado en Politicas Publicas en King's College London (Inglaterra). En este momento, me encuentro en Chile haciendo mi trabajo de campo para mi tesis titulada: **"Understanding constraints to health policy change in Chile: an advocacy coalition framework analysis (2000-2006)".**

Mi investigación busca examinar los factores y actores que intervinieron en la implementación de la reforma a la salud en Chile durante la administración del Presidente Lagos (2000-2006). Este estudio incluye el análisis de documentos y fuentes secundarias, así como entrevistas con actores relevantes durante el proceso en que la reforma fue diseñada, discutida y aprobada. Este grupo de actores incluye autoridades de gobierno, parlamentarios, politicos, representantes del sector privado, y lideres de gremios durante el periodo señalado.

Dada su importante trayectoria y participación en la Comisión de Salud del Senado durante la discusión de la reforma, le agradecería muchísimo si pudiese concederme una entrevista durante las próximas semanas, de acuerdo a su disponibilidad. Yo estaré en Santiago durante todo el mes de Enero de 2014. En caso de que sea posible reunirme con usted, le pido me indique como proceder para coordinarla.

Si necesita más detalles o información acerca de mi proyecto, no dude en contactarme en este correo o en mi teléfono 93689678.

Esperando una buena acogida, se despide atentamente,
Oriana Piffre

****

Oriana Piffre
Phd student
Department of Management
King's College London
Tel UK: +44 7 426004294
Tel Chile: +56 9 93689678

Appendix D. LIST OF INTERVIEWEES

NAME	POSITION	LOCATION
Accorsi, Enrique	Ex-President of *Colegio Medico* (Medical Association) Deputy *Bancada Medica*	Personal Office at the Congress
Artaza, Osvaldo	Former Minister of Health	Skype
Castro, Juan Luis	Ex-President of R of physicians	Personal Office at the Congress
Caviedes, Rafael	Private Insurance Companies	Personal Office
Dávila, Mireya	Advisor President Lagos	Personal Office
Dockendorff, Eduardo	Ex Minister General Secretary of the Presidency	Personal Office
Espinosa, Consuelo	Advisor Ministry of Finance and Health	Home
Figari, Nicolas	Advisor Fundacion Jaime Guzman (Right-wing think tank)	Coffee Shop
García, Pedro	Former Minister of Health	Personal Office
Girardi, Guido	Former Deputy *Bancada Medica*	Chilean Embassy, London
Herrera, Gerardo	Former SEREMI (regional authority)	Skype
Inostroza, Manuel	Director of *Superintendencia* of Health (Regulatory body)	Personal Office
Jiménez, Jorge	Former Minister of Health	Personal Office
Lagos, Ricardo	Past President	Personal Office
Lorenzini, Pablo	Deputy-Ex President Lower Chamber	Home
Maturana, Esteban	President of Health Workers Union	Personal Office
Ottone, Ernesto	Advisor President Lagos	Personal Office
Romero, Andrés	Advisor Minister of Health	Personal Office
Sanchez, Hector	Advisor Centro Salud y Futuro - (Centre-left think tank)	Personal Office
Sandoval, Hernán	Advisor President Lagos	Personal Office
Santelices, Emilio	Doctor-Director of Think Tank Medicos Para Chile	Personal Office
Simon, Gonzalo	Private Insurance Companies	Personal Office
Soto, Sebastian	Advisor Libertad y Desarrollo- (Right-wing think tank)	Skype
Tagle, Andrés	Private Insurance Companies	Personal Office
Tokman, Marcelo	Advisor Ministry of Finance	Coffee Shop
Viera Gallo, Jose A.	Senator	Personal Office

Appendix E. INTERVIEW SCHEDULE

"UNDERSTANDING HEALTH POLICY CHANGE IN POST-DICTATORSHIP CHILE: AN ADVOCACY COALITION FRAMEWORK ANALYSIS (2000-2006)"

PAUTA ENTREVISTAS

BACKGROUND Y RELACION CON EL SECTOR SALUD –

1.Me podría contar acerca de
a) acerca de su rol durante el proceso de la reforma.

I. POSTURAS Y POSICIONES SOBRE LA REFORMA

2. Al inicio del proceso, cual era su nivel de conocimiento acerca de la propuesta del Presidente Lagos,
Respecto de:
-sus orígenes, porque surgió la idea de reforma?
-contenidos específicos del proyecto

3. Cual fue su posición acerca de aspectos particulares de la reforma:
a) financiamiento
b) contenido de la reforma

II. CONTEXTO INSTITUCIONAL DE LA REFORMA

4. Recuerda eventos claves durante el periodo que a su juicio determinaron el resultado?
(-por ejemplo la decisión de aumentar el IVA para financiar la reforma. O las acusaciones de malversación de fondos del Ministerio de salud para promover la reforma en los medios de comunicación. O el cambio o salida de ministros del sector, producto de conflictos políticos al interior de la concertación (salida Bachelet).

5. Que instituciones o conjunto de normas y reglas – afectaron el curso de la reforma?

III. ACTORES RELEVANTES

-quienes eran los actores involucrados inicialmente y sus posiciones

6. En base a su experiencia, cuales fueron las personas o actores que tuvieron mayor influencia en dicho proceso?

De que manera o que estrategias utilizaron? Que obstáculos debieron enfrentar? Obtuvieron los resultados que buscaban?

7. Cree que el sector de salud se asemeja en alguna medida a otros sectores sociales, como educación o el sistema de pensiones? Cuales son sus particularidades?

IV. TOMA DE DECISIONES

9) Respecto del sector salud, usted considera que es un derecho, que debe ser provisto y resguardado por el Estado, o es mas un bien individual a cargo de cada persona?

10) En ese sentido, cual es a su juicio el rol que debe cumplir el estado respecto del sector salud? Promoción de la equidad? o mas bien permitir el funcionamiento del Mercado?; o un balance de ambas? En este sentido, su visión particular cambio durante la reforma?

11) A su juicio, como fue la participación en el proceso de decisiones: fue mas bien un proceso liderado por técnicos, por los gremios, por la elite política, los partidos políticos o algún otro actor?

12) Finalmente, en su opinión, pudo haber una reforma mas radical en el sistema de salud, dado que es una sistema que es siempre señalado como prioridad para los ciudadanos?

13) Hay alguna otra persona que crea usted que pueda ser importante contactar para este estudio?

Oriana Piffre **King's College London** **Enero 2014**

Appendix F. LAW MAKING PROCES